The Journal

of the Michigan State Medical Society

Volume 51 July, 1952 Number 7

All Roads Lead to the 87th Annual Session

(See Page 880)

In hay fever

THE JOURNAL
of the Michigan State Medical Society

VOLUME 51 JULY, 1952 NUMBER 7

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THE JOURNAL
of the Michigan State Medical Society

VOLUME 51 JULY, 1952 NUMBER 7

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Saint Paul 4, Minnesota

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Published monthly by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul 4, Minnesota.

Entered at the post office at Saint Paul, Minnesota, as second class matter, May 7, 1930, under the Act of March 3, 1879.

Acceptance for mailing at special rate of postage provided for in Section 1103 Act of October 3, 1917, authorized August 7, 1918.

Yearly subscription rate, $5.00; single copies, 50 cents. Additional postage; Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year.

PRINTED IN U.S.A.

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You and Your Business

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
DETROIT—September 24-25-26, 1952

DIRECT ENROLLMENT PLAN BLUE CROSS-BLUE SHIELD

July 1-25, 1952

Thousands of persons not eligible for Blue Cross-Blue Shield through a group will be able to obtain hospital and surgical coverage on an individual basis during a state-wide enrollment period set for July 1 through July 25.

This non-group, direct enrollment program, which provides many of the benefits of group coverage, was initiated on a state-wide basis for the first time last September.

Over 75,000 persons enrolled in the three-week period, and because of thousands of requests which have come in since, a similar direct enrollment period was set for July 1 through 25, 1952.

Any person under sixty-five years of age, whether working or retired, may join during that time. However, married persons must enroll spouse and dependents. The spouse can be over 65.

Two contracts are available under the direct enrollment program. One provides a room allowance of up to $8 per day and the other a room allowance of up to $10 per day. They are optional except in Wayne, Oakland, Macomb, Genesee, St. Clair and Lapeer counties, where only the $10 contract is offered.

Otherwise benefits in the two contracts are identical. They provide for coverage without dollar limit of all essential hospital services such as use of the operating room, laboratory, anesthesia, physical therapy and drugs and dressings.

On the family contract, maternity benefits of up to $9 per day plus a $50 fee to the doctor under the surgical certificate are provided nine months after the effective date of the contract.

The direct enrollment contract entitles every member on the contract to thirty days of hospital care and another thirty days, six months after the first thirty days has been used up.

No physical examination or health statement is required. Because there is a specific and limited enrollment period, Blue Cross is able to cover even pre-existing and chronic conditions six months after the effective date of the contract. Acute conditions are covered immediately.

Enrollment will be by mail or by applying in person at any Blue Cross-Blue Shield office. Applications and folders outlining details and cost of coverage can be obtained by mailing an inquiry card, mailing in the coupon which will appear in newspaper advertisements, or by calling a Blue Cross office (Main Office: 234 State Street, Detroit).

The Blue Cross-Blue Shield direct enrollment campaign has the full endorsement and co-operation of the Michigan State Medical Society and the Michigan Hospital Association.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of May 24, 1952

Sixty-one items were presented to the Executive Committee of The Council on May 24. Chief in importance were:

- Financial Reports were presented, studied and approved.
- Bills Payable were presented and payment was authorized.
- Health and accident insurance plan for MSMS members: this proposal was presented by the MSMS Insurance Studies Committee, W. S. Jones, M.D., Menominee, Chairman. The details as devised by the insurance brokers were thoroughly discussed and the Committee was requested to file a written report for presentation to The Council at its July, 1952, Session.
- American Medical Education Foundation. Follow-up organizational work in Michigan, as recommended by Councilor G. B. Saltonstall, M.D., Charlevoix (MSMS representative to AMEF), was presented and accepted. Action to carry out the recommendation was ordered.
- H. F. Mattson, M.D., Hillsdale; G. W. Slagle, M.D., Battle Creek; and J. D. Littig, M.D., Kalamazoo, were appointed as MSMS representatives to serve on the Planning Committee for the Southwestern Nurses Regional Conference, scheduled for Hillsdale in the autumn of 1952.
- Committee Reports—the following were given consideration: (a) Committee to Meet with Basic Science Board Officers, meeting of April 23; Mental Hygiene Committee, meeting of May 1; Rheumatic Fever Control Committee, meeting of May 7; Committee on Survey of Hospital Facilities at State Prison of Southern Michigan, meeting of May 7; Cancer Control Committee, meeting of May 8; Committee to Study Veterans Administration Hospital Policy, meeting of May 13; Beaumont Memorial Res-

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HIGHLIGHTS OF THE COUNCIL

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toration Committee, meeting of May 13; Permanent Conference Committee, meeting of May 14; Committee to Study Proposed AMA Reorganization—report referred to Michigan Delegates to AMA House of Delegates; Joint Committee on MSMS and Michigan Health Council re Periodic Health Appraisal, meeting of May 19.

- President Otto O. Beck, M.D., reported on contributions to date to the Beaumont Memorial Restoration Fund.
- Dispensing barbituric acid preparations without proper labeling and marking on the containers, and not indicating the name of the patient as provided in the Dangerous Drug Act: a letter on this subject from the Director of Drugs and Drug Stores, Michigan Board of Pharmacy, was presented and referred for publication in JMSMS and in the next Secretary's Letter to all members.
- Request of American Hospital Association for an MSMS representative to speak at its annual convention in Philadelphia, September 18, on "Medical Staff Participation in Reducing Patient Costs": Kenneth B. Babcock, M.D., Detroit, was appointed as MSMS representative for this presentation.
- Monthly report of Rheumatic Fever Coordinator Leon DeVel, M.D., was presented and accepted.
- The progress report of the Public Relations Counsel included listing of the MSMS television shows; the Formula For Freedom Nights throughout the State; appointment of Warren F. Tryloff as Field Secretary to the Michigan Health Council; reprinting of Medical Associates brochure (10,000 copies) with request for 27 copies from the Office of the President of the United States; and a report on four different plans to reapportion the Michigan Legislature.
- Matters presented by Michigan Health Commissioner A. E. Heustis, M.D., included request for help in finding a physician for Beaver Island; changes in the laws governing registration of births and deaths; decrease in the size of the Michigan Health Department personnel; progress in Medical Civil Defense; special Venereal Disease and Tuberculosis Survey in Detroit; joint efforts of MSMS Child Welfare Committee and the State Health Department in the control of certain communicable diseases; and a request that MSMS review the public health programs of the State "so that sound and worthwhile recommendations might be available in the case of future activity in governmental reorganization of the health field."
- An invitation to all members of the MSMS Council and to all MSMS members to attend the Upper Peninsula Medical Society meeting in Iron Mountain on June 27-28 was extended by AMA Delegate W. H. Huron, M.D., of Iron Mountain.
- Thanks were extended to W. S. Jones, M.D., Menominee, who acted as host at this meeting.

ESSAYISTS FOR ANNUAL SESSION

The Michigan State Medical Society Annual Session will be a great gathering of medical folk at the Sheraton-Cadillac Hotel, Detroit, September 24, 25 and 26. No registration fee to MSMS members. Get your hotel reservations *now* by writing Committee on Housing, c/o Sheraton-Cadillac Hotel, Detroit, Attention: Robert M. Buckley, Secretary.

Some of the guest essayists who already have accepted invitations to speak at the MSMS Annual Session are: Claude S. Beck, M.D., Cleveland; John J. Bonica, M.D., Tacoma, Wash.; George Crile, Jr., M.D., Cleveland; Ormond S. Culp, M.D., Rochester, Minn.; Daniel C. Darrow, M.D., New Haven, Conn.; Edwin J. DeCosta, M.D., Chicago; Garfield G. Duncan, M.D., Philadelphia; Dwight E. Harken, M.D., Boston; Peter C. Kronfeld, M.D., Chicago; Milton I. Levine, M.D., New York; Roland P. MacKay, M.D., Chicago; Samuel F. Marshall, M.D., Boston; Earl R. Miller, M.D., San Francisco; Emil Novak, M.D., Baltimore; Duncan E. Reid, M.D., Boston; David A. Rytand, M.D., San Francisco; Ben H. Senturia, M.D., St. Louis, Mo.; Evan W. Thomas, M.D., Albany, N. Y.; Philip Thorek, M.D., Chicago; Leonard F. Weber, M.D., Chicago; and Claude E. Welch, M.D., Boston.

IT WOULDN'T WORK

The well-advertised Social Security Hospitalization scheme is fundamentally unsound, economically.

The Social Security Agency states that the cost of this hospital program could be paid out of the Social Security surplus. While there is an unexpended balance in Social Security collections, we must remember that most of the contributors are still young and have not reached the retirement age, and therefore continue to pay dues; however, if Social Security were ended as of today, all of the surplus and more would be required to liquidate the contracts that the government has entered into with the present contributors. That's one reason why Altmeyer has asked that the dues for Social Security be increased.

Under the proposal, the impression is gained that hospitalization would be guaranteed to all beneficiaries under Social Security. Actually the government's contract is not to guarantee one bed in a hospital, but only to assume the payment up to sixty days in a semi-private room—if the patient is fortunate enough to get admitted.

The hospitals would be the real beneficiaries under this plan, as admitted by the Federal

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IT WOULDN'T WORK

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Security Agency. Hospitals are already crowded, and if this extra burden were to be added to them, the situation would be considerably aggravated in certain areas. In other words, patients would not be able to gain hospitalization in some sections of the country (as in most parts of England at the present moment).

Inasmuch as the hospital benefits would be available to all contributors under the Social Security Law (with no means test), one can readily see how the number of potential applications for hospital benefits would annually increase.

The Social Security Agency would give the impression that this program could be instituted and administered without increase in taxation. Such an idea is entirely unwarranted.

This so-called "insurance" would be mandatory: the worker would pay whether he wants the service or not. Yet FSA cannot guarantee that he would be able to get into a hospital if, after sixty-five, he needs hospitalization.

It's all a New Deal bureaucratic mirage!

FORMULA FOR FREEDOM NIGHTS

Twenty-two (22) Formula For Freedom Nights sponsored by the Michigan State Medical Society and held during the winter and spring seasons were climaxed June 27 at the meeting of the Upper Peninsula Medical Society, Iron Mountain.

At the June 27 U.P. luncheon meeting, the Formula For Freedom presentation was made to the members of all county medical societies in the Upper Peninsula. The speakers were L. Fernald Foster, M.D., Bay City; D. Hale Brake, Lansing, Treasurer, State of Michigan; and Hugh W. Brenneman, Lansing, MSMS Public Relations Counsel.

OREGON MEDICAL SOCIETY VINDICATED

The sale of medical service is not trade or commerce.

Doctor-sponsored prepaid medical plans won a major victory in the United States Supreme Court decision handed down on April 28 in favor of the Oregon State Medical Society. This organization had been charged by the Federal Government with conspiring to monopolize the business of providing prepaid medical care in the State of Oregon and conspiring to restrain competition between medical plans within the state in violation of the Sherman Anti-Trust Act. In affirming the trial court's decision, the U. S. Supreme Court held:

"The sale of medical services by doctor-sponsored organizations in the State of Oregon is not trade or commerce within the meaning of the Sherman Anti-Trust Laws. Nor is it commerce within the meaning of the constitutional grant of power to Congress 'to regulate commerce among the several states.'"

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1952

July 24-25	Annual Coller-Penberthy Medical Surgical Conference.....Traverse City
July 24-26	Conference on Housing of the Aging Ann Arbor
August 21	Third Annual Clinic, Central Michigan Committee, ACS Michigan Committee on Trauma, plus Michigan National Guard Medical Personnel, and Medical Society of North Central Counties Grayling
Sept. 24-26	MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION.....Detroit
Oct. 8	Clara Elizabeth Fund—Genesee County Medical Society—Lectures of 1952...Flint
Oct. 9	Fourth Michigan Cancer Conference Kellogg Center, East Lansing
Nov. 17-18	Wayne County and Michigan Academies of General Practice..... Kellogg Center, East Lansing
Autumn	MSMS Postgraduate Extramural Courses State-wide

1953

April 9	Genesee County Medical Society 8th Annual Cancer Day.....Flint
May 13	Annual Clinic Day and Reunion of Wayne University College of Medicine Hotel Fort Shelby, Detroit

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

Oscar C. Pogge, director of Bureau of Old Age and Survivors Insurance, reports that 4,600,000 persons now are on OASI rolls; the total will be 7,195,000 by 1960 and by the year 2000 it will be 19,872,000.

"...particularly beneficial in the treatment of hay fever."[1]

Because CHLOR-*TRIMETON*® maleate, chlorprophenpyridamine maleate, has the greatest potency milligram for milligram of any available antihistamine, and because "Chlor-Trimeton has a relatively low incidence of side reactions,"[2] it is a drug of choice for hay fever patients.

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1. Silbert, N. E.: New England J. Med. *242*:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet *70*:26, 1950.

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Heart Beats

RESEARCH ACTIVITIES SUPPORTED BY THE MICHIGAN HEART ASSOCIATION

FRANKLIN D. JOHNSTON, M.D.
Chairman, Research Committee Michigan Heart Association
Ann Arbor, Michigan

Many physicians in this state may not appreciate the diversity and extent of the investigations in the field of cardio-vascular disease being carried out in Michigan with funds provided by the Michigan Heart Association or how these studies may help them to take better care of patients suffering from disorders of the heart and vascular system. Over $65,000.00 will be spent by eighteen different groups of research workers during the period from July 1, 1951, to July 1, 1952, and nearly $85,000.00 has been allocated to support continuing or new projects during the next year. These are large amounts of money, even in these days, and some comments regarding what has already been accomplished and work in progress or in prospect is clearly in order.

It should be pointed out that most of the money available to the Michigan Heart Association for research or other purposes comes from the public through the United Health and Welfare Fund of Michigan and the United Foundation in Detroit and the Research Committee, as well as other groups in the Association, are keenly aware that these funds must be used in the best possible way. Many of the research activities are concerned with studies on patients, and it is often difficult to say whether certain costs may properly be considered part of the research program or whether they should be included as items under routine patient care. The Research Committee has taken a very definite stand on this matter and in general does not look favorably on requests for money to pay for hospitalization of patients, professional fees of any kind, or any of the other costs commonly borne by the patient. Only under exceptional circumstances have funds been granted for studies which are closely related to the care of patients.

Funds for the purchase of ACTH or cortisone to treat patients with acute rheumatic fever have been given to three groups of workers, one in Detroit, one in Grand Rapids and one in Ann Arbor. Although approval of these grants might be considered as a violation of the general policy expressed above, it was felt that the importance of the matter under investigation far outweighed other considerations. Preliminary results which have already been reported by Doctors Wooley and Hecht from the Children's Hospital in Detroit indicate these endocrine preparations have a definite place in the treatment of acute rheumatic infection.

Most of the money allocated for research activities has been or will be spent to support young physicians devoting all or part of their time to research work, to pay the salaries of technicians, and to purchase equipment and supplies of many kinds. The Research Committee does not think it likely that any great discoveries will be made or any revolutionary new treatments for heart disease will be devised in the near future, but they do believe that important facts will be uncovered and new techniques for diagnosis and treatment will be perfected. These contributions, although small, may in the long run help immeasurably in the management of cardiac patients. A cardinal principle in the granting of funds has been to give money to individuals or groups of individuals who have already demonstrated ability to carry out research work of high grade and to allow them to go ahead with the studies that interest them.

Space is not available to even mention all of the research projects sponsored wholly or in part by the Michigan Heart Association, so only a few of the representative ones will be presented here. Studies of several kinds are being carried out in the departments of Medicine and Chemistry of Wayne University in Detroit under the supervision of Dr. Gordon B. Myers. These include work on the metabolic aspects of cardiac and renal diseases, hemodynamic aspects of cardiac and pulmonary

(Continued on Page 808)

RESEARCH ACTIVITIES

(Continued from Page 806)

diseases and studies on atherosclerosis. Studies on patients and experimental animals which involve extensive chemical work and development of new techniques and methods have already led to many papers for presentation at scientific meetings and many publications. The work of this excellent group of investigators will be materially aided by the completion of a new cardio-vascular research unit, now under construction in the annex of Receiving Hospital.

Important work relating to nutrition in patients with rheumatic fever and rheumatoid arthritis is being done in the Henry Ford Hospital under the direction of Dr. Joseph A. Johnston. Dr. Conrad R. Lam and associates in the same Hospital are continuing experimental studies which have already contributed a great deal to the surgical treatment of several different kinds of congenital and acquired cardio-vascular diseases. Dr. F. D. Dodrill of the Harper Hospital in Detroit is working intensively to develop artificial heart-lung mechanisms which have already given promising results on experimental animals and may, in the future, aid greatly in surgical treatment of cardiac defects. Studies on experimental myocardial infarction in dogs being carried out in Harper Hospital by Doctors Johnson, Gerisch, Saltzstein and Scheinberg are of great interest, since preliminary work suggests that animals receiving cortisone after the ligation have an increase in the vascularity of the heart and smaller infarcts as compared with control animals not receiving the drug. The implications of this study are of great importance, and further studies are under way.

Special techniques have been developed for the recognition of a pressor substance by Doctor Sibley W. Hoobler and associates in Ann Arbor, and they are working to identify and isolate the material from the blood of patients with essential hypertension. Studies, also being carried out in Ann Arbor by Doctor F. E. Shideman in the department of Pharmacology, are concerned with mechanisms for reabsorption of sodium by the renal tubules. This work may bring to light information which will provide effective means of increasing elimination of sodium by the kidney and aid in the reduction of edema.

Some of the activities mentioned above may be of immediate practical value, while others may not. All of them, however, represent earnest efforts to widen our field of knowledge and improve methods for the diagnosis and treatment of cardio-vascular disease. The Michigan Heart Association is proud to help in this work.

MICHIGAN'S TAX "PUT" RISES AS "TAKE" FALLS

Amateur card players know that in a poker game operated by professionals all the money poured into the pot doesn't come back out.

Likewise, taxpayers know that the money they shower on the Federal Treasury doesn't all come back to their various states in the form of Federal assistance or grants-in-aid.

In a poker game or at a horserace track the "take" is reasonably stable.

But in Government the percentage returned to the donors fluctuates wildly.

Some needy states, poor in resources, pay little taxes but get large grants. Others contribute heavily but get relatively little assistance from the Federal Government.

Michigan consistently is in the latter group.

In 1951, it took a particularly bad beating.

Compared with 1950 figures, Michigan's hard-working citizens boosted their Federal tax payments by 51 per cent.

But in spite of their increased contribution, the State's Federal grants-in-aid were cut nearly six per cent!

The two years compare thus:

Federal Tax Collections	
1950	1951
$2,747,571,000	$4,156,022,000
Federal Grants	
86,962,000	81,817,000

In the fiscal year 1951, Michigan was third on the list of states carrying the greatest Federal tax burdens. The first five were:

New York	$9,243,924,000
Illinois	4,329,996,000
Michigan	4,156,021,000
Pennsylvania	3,886,470,000
California	3,558,227,000

The money was paid into the United States Treasury mostly through individual income-tax payments and corporation taxes.

Other sources were excise taxes, employment levies, customs collections and other minor taxes.

Of the champion contributors listed above, four were among the five states that received the most in Federal grants-in-aid.

The top five were:

California	$202,823,232
New York	156,171,464
Texas	118,139,549
Pennsylvania	106,814,743
Illinois	92,414,746

Michigan was one of 17 states that got less financial assistance from Federal sources in 1951 than it did in 1950. The remaining 31 got more than they did in 1950.

The question facing Michigan's industrious citizens at a time when they are paying record-high taxes is: Is it really better to give than to receive?

Politics and Medicine

The city-operated General Hospital of Bay City has, since its inception, been a medical institution staffed by doctors of medicine of Bay City and environs.

On June 9, 1952, the members of the Bay City Commission, by a vote of five to four, authorized osteopaths, of whom there are eight in the city, to practice in the 154-bed General Hospital. This action forced out of the hospital the seventy medical doctors, who comprised the staff, since the principles of medical ethics of the American Medical Association specifically state, "All voluntarily associated activities with cultists are unethical. A consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice" (Chapter II, section 1). Moreover, the Bay County Medical Society members realized that Bay City General Hospital would lose its accreditation with the American College of Surgeons if osteopaths were permitted to practice therein.

Within a week, the number of patients at General Hospital dwindled to thirty-two as doctors of medicine began treating their patients in Mercy Hospital and other hospitals of the area. This was in spite of the oftrepeated boast of the osteopathic leaders that they would completely staff and fill General Hospital with patients, in case the City Commission turned the hospital over to them. At no time did the osteopaths have more than sixteen cases—eight of these being tonsillectomy cases (and nine were from outside of the City of Bay City).

Faced with a daily deficit of over $2,000, the City Commission reversed itself, again by a vote of five to four, at its meeting of June 16. Immediately, the patients of medical men were moved into the hospital, as they desired to go to General Hospital.

The Bay City experience, although most unfortunate, gives further proof to the well-known fact that politics can be fought only by politics. Individual members of the medical profession must understand and become a directing force in politics or else they will be engulfed by politics.

DIETARY NOTES

Construing "Dietetics" as a triumph of mind over platter, we give you daffynitions of some of the common dietary terms, intended to stimulate the mental, rather than the digestive processes:

Eggplant—pumpkin with apoplexy.

Beans—a vegetable that someone is always spilling.

Onions—a vegetable that builds you up physically, but tears you down socially.

Peas—vegetable pills.

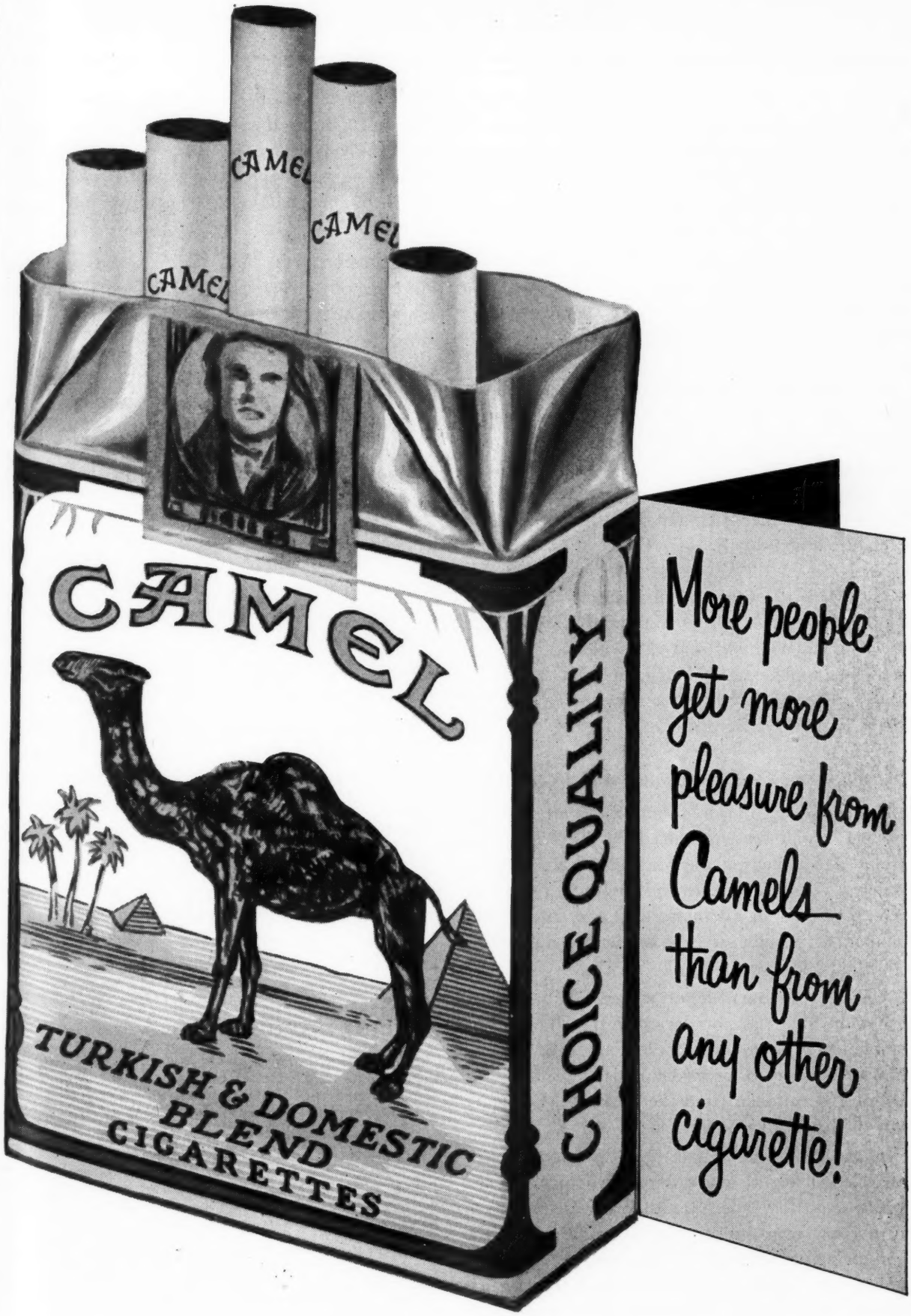
Beets—potatoes with high blood pressure.

Hash—a food that isn't made but just accumulates.

Vegetable soup—the same as hash, except that it is looser.

Vegetarianism—a harmless practice, though it is apt to fill a man with wind and self-righteousness.

Please be seated!—*Kiwanis News Letter.*



Medicine and TV

Phase One of a successful television program has been completed by the doctors of medicine of the Michigan State Medical Society. And without a break in continuity, Phase Two of the production has been taken up by the Michigan Health Council.

After a year and a half of successful weekly television shows in a series called "It's Your Life," MSMS concluded the series on May 28, 1952. The weekly shows had been broadcast each Sunday since December 17, 1950, over WJBK-TV (Channel 2), Detroit.

The Michigan Health Council is producing a series called "Court of Health." This program is telecast in the time slot on WJBK-TV originally occupied by "It's Your Life." MSMS Public Relations Committee members are on the TV Committee of the Michigan Health Council. It is chairmanned by R. W. Teed, M.D., of Ann Arbor.

The Michigan State Medical Society, however, is still very active in the production of television shows. Each Wednesday at 12:00 Noon, doctors of medicine appear on a half-hour portion of the "Bud Lanker Show" which is televised on WXYZ-TV (Channel 7), Detroit.

Seventy-One TV Shows Sponsored by MSMS

Before "It's Your Life" went off the air, seventy-one shows had been produced by the Public Relations Department of the Michigan State Medical Society. These three score and eleven presentations were presented in an interesting and informative manner to possible weekly audiences numbering 1,000,000 televiewers.

A heavy response of letters served as a barometer to demonstrate the popularity of the show. The topics of each show covered every aspect of medical science. The doctor of medicine participants in the program were taken from the ranks of Michigan's own medical practitioners.

In the year and a half that "It's Your Life" was telecast, eighty-one different Michigan M.D.s appeared on the show in addition to twenty-seven lay persons who had a particular interest in the topic being considered for that week.

When the Michigan State Medical Society first entered the field of television, few other state societies had taken the plunge into the new medium. Since that time, however, other state medical societies and the American Medical Association have seen the possibilities of TV as an outlet for information of a health nature and are using it.

The early "It's Your Life" shows used Jack Pickering of the *Detroit Times* as moderator. Later John Holland of Detroit became the M.C. of the show.

Motion pictures screened on the program supplemented the information supplied by the participating doctors of medicine. In fact, it was on "It's Your Life" that the latest Michigan State Medical Society film "To Save Your Life" was given its television premiere.

Credit for the success of the television production goes to the doctors of medicine and other participants who were willing to give up their Sunday mornings to take part in the show. The Michigan State Medical Society extends to these doctors a sincere vote of thanks for their unselfish response to requests to appear on the show.

Television has become an important part in the lives of a majority in the United States. This new medium has tremendous possibilities for presentations by the medical profession. As time goes on, these TV possibilities will be explored further by MSMS.

"It's Your Life" and its successor, the "Court of Health," are only the beginning.

DEVELOP PLASTIC SURGICAL INSTRUMENTS

Surgical instruments made from methyl methacrylate resin (lucite, trade mark) have proved superior in many ways to their metal counterparts, it was reported in the July 12 *Journal of the American Medical Association.*

Developed for use in neurosurgical operations, the transparent plastic instruments are easy to make, inexpensive, easily handled and light in weight, according to Dr. Frank T. Padberg, of the department of surgery, Northwestern University Medical School, Chicago. Dr. Padberg designed the instruments.

In addition, he reported, the instruments are transparent so that underlying matter can be seen, they reflect light poorly, they do not conduct the electrocoagulating current, they are sufficiently strong, and they are durable.

"IT'S YOUR LIFE" SHOWS

December 17, 1950, to May 25, 1952

WJBK-TV (Channel 2) Detroit

PARTICIPANTS	TOPIC	DATE
W. B. Cooksey, M.D., Detroit	Heart	December 17, 1950
George Thosteson, M.D., Detroit	Diabetes	December 24, 1950
F. J. Hodges, M.D., Ann Arbor	Cancer	December 31, 1950
Carleton Dean, M.D., Lansing	Amputees	January 7, 1951
Arch Walls, M.D., Detroit	Family Doctor	January 14, 1951
A. H. Whittaker, M.D., Detroit	Industrial Health	January 21, 1951
E. F. Lutz, M.D., Detroit		
LeMoyne Snyder, M.D., Lansing	Legal Medicine	January 28, 1951
W. S. Reveno, M.D., Detroit	Goiter Areas	February 4. 1951
H. B. Zemmer, M.D., Lapeer	Epilepsy	February 11, 1951
A. E. Schiller, M.D., Detroit	Skin Diseases	February 18, 1951
Mr. Emmet Richards, Alpena	Crippled Children Commission	February 25, 1951
Frank Van Schoick, M.D., Jackson		
L. Fernald Foster, M.D., Bay City	History of Medicine	March 4, 1951
J. J. Lightbody, M.D., Detroit	Arthritis	March 11, 1951
Earl Merritt, M.D., Detroit	Relationship Between Pharmacist and Physician	March 18, 1951
Dean C. H. Stocking, Ann Arbor		
A. C. Furstenburg, M.D., Ann Arbor	Doctor's Training	March 25, 1951
Gordon H. Scott, Ph.D., Detroit		
R. W. Teed, M.D., Ann Arbor	What the Health Council	April 1, 1951
J. S. DeTar, M.D., Milan	Could Do For You	
Mrs. Marjorie Karker, Lansing		
Mr. E. H. Wiard, Lansing		
Mr. H. W. Brenneman, Lansing		
J. G. Bielawski, M.D., Detroit	Cardiac Housewife	April 8, 1951
Claire L. Straith, M.D., Detroit	Plastic Surgery	April 15, 1951
Ralph Pino, M.D., Detroit	Cataract	April 22, 1951
R. K. Whiteley, M.D., Detroit	Pregnancy	April 29, 1951
J. G. McIner, M.D., Detroit	Detroit Health Department	May 6, 1951
Raymond W. Waggoner, M.D., Ann Arbor	Emotional Factor in Diseases	May 13, 1951
A. E. Heustis, M.D., Lansing	Blood	May 20, 1951
Harland Anderson, Ph.D., Lansing		
Otto van der Velde, M.D., Holland		
Ralph Johnson, M.D., Detroit	Vacation Safety	May 27, 1951
Mr. Palmer Bunker, Lansing		
Mr. Bennett McCarthy, Detroit		
Mr. C. F. Van Bankensteyn, Lansing		
Robert Mason, M.D., Detroit	Pediatrics	June 3, 1951
B. E. Brush, M.D., Detroit	Iodized Salt	June 10. 1951
O. B. McGillicuddy, M.D., Lansing	Hearing Defects	June 17, 1951
W. H. Gordon, M.D., Detroit	Your Doctor in War	June 24, 1951
John Towey, M.D., Powers	Tuberculosis	July 1, 1951
G. T. McKean, M.D., Detroit		
Alice Palmer, M.D., Detroit	Sunburn	July 8, 1951
Edwin DeJongh, M.D., Detroit	Migraine headache	July 15, 1951
Archibald MacGregor, M.D., Brighton	First Aid	July 22, 1951
Frederick Swartz, M.D., Lansing	Old Age	July 29, 1951
Edgar Martmer, M.D., Detroit	Poliomyelitis	August 5, 1951
Max Newman, M.D., Detroit		
Harold Kullman, M.D., Dearborn	Veteran Rehabilitation	August 12, 1951
Joseph Markel, M.D., Dearborn		
L. Fernald Foster, M.D., Bay City	Michigan Medical Service	August 19, 1951
R. L. Novy, M.D., Detroit		
Mr. Jay Ketchum, Detroit		
Mr. William S. McNary, Detroit	Blue Cross-Blue Shield	August 26, 1951
Mr. William Klein, Flint		
Kenneth Babcock, M.D., Detroit		
Wilfred S. Nolting, M.D., Detroit	Life of a Healthy Child	September 2, 1951
No Production		September 9, 1951
Roy D. Tupper, M.D., Detroit	Rheumatic Fever	September 16, 1951
David Sandweiss, M.D., Detroit	Ulcers	September 23, 1951
H. Marvin Pollard, M.D., Ann Arbor		
F. D. Dodrill, M.D., Detroit	Blue Babies	September 30, 1951
William Blodgett, M.D., Detroit	Foot Health	October 7, 1951
J. G. Reid, M.D., Detroit		
C. E. Umphrey, M.D., Detroit	Hernia	October 14, 1951
Eugene A. Osius, M.D., Detroit		
Harold G. McLean, M.D., Detroit		

(Continued on next page)

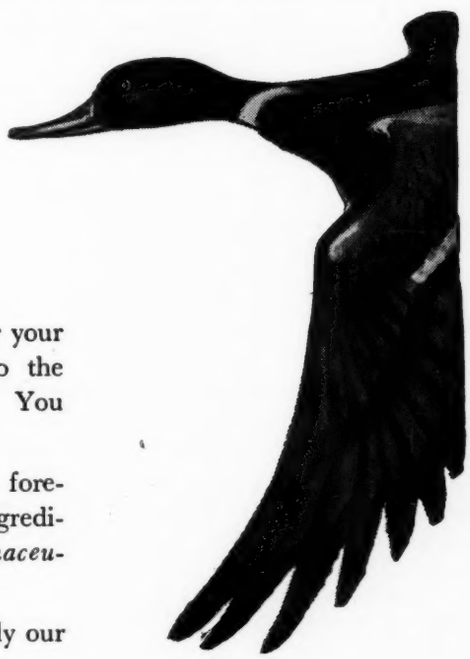
"IT'S YOUR LIFE" SHOWS

(Continued from Preceding Page)

PARTICIPANTS	TOPIC	DATE
James Croushore, M.D., Detroit	The Throat and Its Importance	October 21, 1951
Charles G. Jennings, M.D., Detroit	Baby's First Year	October 28, 1951
Donald H. Kaump, M.D., Detroit	Blood Banks	November 11, 1951
E. D. Spalding, M.D., Detroit	Underweight and Overweight Problems	November 18, 1951
C. A. Payne, M.D., Grand Rapids	The "RH" Factor	November 25, 1951
A. D. Ruedemann, M.D., Detroit	Eyesight	December 2, 1951
Willard W. Dickerson, M.D., Caro	Epilepsy	December 9, 1951
Lyle G. Waggoner, M.D., Detroit	Bronchology	December 23, 1951
Mr. Hugh W. Brenneman, Lansing Mr. Gene Wiard, Lansing H. B. Zemmer, M.D., Lapeer W. C. Baguley, Lansing	Advantages of a Rural Health Conference	January 6, 1952
Harold W. Longyear, M.D., Detroit Harold A. Ott, M.D., Detroit Harry A. Pearse, M.D., Detroit	Childbirth Safety	January 20, 1952
R. W. Teed, M.D., Ann Arbor Lawrence Drolett, M.D., Lansing Rep. Howard R. Estes, Birmingham Rep. Martha Griffiths, Detroit	Public Health	January 27, 1952
Franklin D. Johnston, M.D., Ann Arbor Warren B. Cooksey, M.D., Detroit Conrad Lam, M.D., Detroit Robert F. Ziegler, M.D., Detroit	New Hope for Hearts	February 3, 1952
Senator Felix H. H. Flynn, Cadillac Ralph Johnson, M.D., Detroit	Your Life after 65	February 10, 1952
Senator Elmer R. Porter, Blissfield Henry A. Luce, M.D., Detroit Raymond W. Waggoner, M.D., Ann Arbor	Mental Illness	February 17, 1952
Oliver Field, A.M.A., Chicago	Electronic Radioclast	February 24, 1952
C. I. Owen, M.D., Detroit Le Moyne Snyder, M.D., Lansing Rep. Richard L. Thomson, Highland Park Rep. William P. Littlewood, Wyandotte	Medical Examiners System	March 2, 1952
Harold Henderson, M.D., Detroit G. C. Penberthy, M.D., Detroit	Michigan Clinical Institute	March 9, 1952
Otto O. Beck, M.D., Birmingham A. H. Whittaker, M.D., Detroit	Beaumont Memorial	March 16, 1952
O. D. Stryker, M.D., Mount Clemens Rep. Robert Montgomery, Lansing	Communicable Diseases	March 23, 1952
J. K. Altland, M.D., Lansing John Martin, Auditor General, Lansing	Public Health	March 30, 1952
Mr. Martin Fleming, Detroit Mr. John Lee, Detroit	Rheumatic Fever	April 6, 1952
No Production		April 13, 1952
Mr. Warren R. Mullen, Ann Arbor J. S. DeTar, M.D., Milan	The Family Doctor	April 20, 1952
L. Fernald Foster, M.D., Bay City D. Hale Brake, Lansing Hugh W. Brenneman, Lansing	Formula For Freedom	April 27, 1952
Francis P. Walsh, M.D., Detroit	Cerebral Palsy	May 4, 1952
Harold B. Fenech, M.D., Detroit	General Surgery	May 11, 1952
J. E. Livesay, M.D., Flint	Radiology	May 18, 1952
Louis Jaffe, M.D., Detroit Max L. Lichter, M.D., Detroit	Medical Aspects of Civil Defense	May 25, 1952

"THERE'S ALWAYS A

Leader. . . . . MALLARD, INC."



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You may buy a chair for your office or gasoline for your car that's good as most. But when it comes to the patient's health you get the finest products made. You insist on that.

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Karl O. Mallard
President, Mallard, Inc.

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Cancer Comment

IS PROFESSIONAL CANCER EDUCATION BEING OVERDONE?

A thirty-five-year-old woman was having persistent irregular vaginal bleeding. She consulted a gynecologist who prescribed hormones to control the bleeding and told her to return in two weeks when he would make a vaginal examination if the bleeding had ceased or would continue hormones until the bleeding stopped. As she continued to bleed, hormones continued to be given without a vaginal examination. This continued for several months without any lessening of hemorrhage or a vaginal examination.

Tiring of this form of treatment and becoming more concerned about her condition, the patient consulted another physician, who promptly made a pelvic examination and discovered a large pedunculated polyp protruding from the cervical os. Fortunately, it was found to be a benign growth. Had it been malignant, it does not require a very active imagination to realize the danger to this patient's life due to the neglect of the first physician to make a pelvic examination "until after the bleeding has been controlled."

* * *

An obese married woman, aged twenty-eight, sought medical attention in October for overweight. A pelvic examination was done and reported as "a tumor or pregnant." Friedman test was negative. Menses continued for five months, the abdomen continuing to enlarge. In the following March the same physician again examined the patient, who was told "he could not tell if she was pregnant."

Dissatisfied with the medical opinions already given, three months later the patient was examined in another hospital where again she was told she was pregnant. Bleeding continued. Another examination late in June, nine months after her first examination, resulted in decision she was not pregnant.

Patient was admitted to a hospital in July, and laparotomy revealed pelvic organs in such condition "it was not possible to remove them." X-ray treatments were given in August and September. The following January panhysterectomy and bilateral salpingo-oöphorectomy was done, with findings of primary right ovarian papillary carcinoma with metastases.

In this case, diagnosis was established *only after 14 months delay.*

* * *

From the *Westchester Medical Bulletin* (Westchester County, N. Y.) May, 1952, issue, the following case is cited: "I first noticed the lump in my breast over a year ago; it didn't bother me but I thought I should tell my doctor. He said we should 'watch it.' I saw him several months later, and it hadn't changed in any way so he said to 'watch it.' I was in an auto accident and was examined by another doctor. I asked him about it, and he said it would be all right to 'watch it.' Finally a friend of mine urged me to see another doctor. He explained it was probably not serious but would best be out. Now I know that it was cancerous and I have had what they call a 'radical'; I feel fine and my doctor is very hopeful that I have been cured!"

This is a verbatim report from a forty-year-old intelligent and "well adjusted" business woman in Westchester County, and the date is 1952.

No further comment is necessary!

* * *

The cases cited above could be multiplied over and over from the records of many hospitals. Watching breast lumps and waiting for hemorrhage to cease before making pelvic examinations are dooming many women to needless suffering and often to premature deaths. Examination during pelvic hemorrhage holds the distinct advantage of being able to accurately localize the source of the bleeding and any solitary lump in the breast persisting after the next menstrual period following its discovery demands prompt and definite diagnosis.

Professional cancer education has stressed these points year after year; still they are neglected by far too many physicians in their daily practice. Is too much emphasis being given to professional cancer education? From the cases cited above and from many other similar cases that could be produced, the answer to this question must be in the negative. It is up to each physician to answer this question through his handling of his own cancer patients.

Since it is clinically impossible to distinguish between a benign solitary adenoma and a low grade carcinoma of the thyroid, discrete adenomas should be removed completely by excising the entire lobe on the affected side.

* * *

Thorough and complete removal of thyroid carcinomas and their regional metastases is the safest and most dependable treatment now available.

* * *

The most radical operations performed within a few weeks or months of the onset of undifferentiated carcinomas of the thyroid have failed consistently to effect cures.

* * *

Roentgen therapy is of little value in the well-differentiated carcinomas of low malignancy of the thyroid and should not be given prophylactically to prevent the recurrence of tumors which apparently have been excised completely.

MEAT... and the Cholesterol Content of the Diet

An essential constituent of human tissue, contributing to the normal functioning of all cells, cholesterol has been widely discussed as a factor in the etiology of atherosclerosis. Yet this lipid is required in many metabolic processes, and, furthermore, evidence is lacking that withholding cholesterol from the dietary is effective in preventing atherosclerosis.

In a recent plea for a return to the basic fundamentals of nutrition in the prophylaxis of atherosclerosis, it was emphasized that to eliminate cholesterol from the diet would mean to eliminate such animal foods as meat, milk, eggs, etc.* However, nutritionists are unanimous in asserting that these protective foods contain basic essential nutrients required for good nutrition and that to deny them would be "equivalent to the negation of practically all that nutrition science has taught us in the past."

According to these authors,* elimination of animal foods from the diet to prevent the development of atherosclerosis is unjustified on the basis of present day knowledge. They state that "there certainly is no evidence that meatless, milkless, and eggless diets should be recommended as desirable to the general public."

Meat, America's favorite protein food, always has been and continues to be an important dietary source of biologically complete protein, B vitamins, and iron. Few indeed are the conditions in which its use must be interdicted.

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*Hegsted, D. M.; Mann, G. V., and Stare, F. J.: Comments on Cholesterol, Editorial, Postgrad. Med. *11*:454 (May) 1952.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute
Main Office, Chicago... Members Throughout the United States

Editorial Comment

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
SHERATON-CADILLAC HOTEL—DETROIT
September 24-25-26, 1952

VOLUNTARY PENSIONS FOR PHYSICIANS

Elsewhere in this issue (page 391) is an analysis of the Keogh-Reed bills (H. R. 4371 and H. R. 4373), which would encourage by tax deferment a voluntary pension system. This article is an abstract of the testimony given on May 13, 1952, in Washington at the hearings of the House Committee on Ways and Means by Frank G. Dickinson, Ph.D., for the American Medical Association. Similar encouragement is now given to employed persons under Section 165 and related sections of the Federal Internal Revenue Code. An editorial on this subject appeared in *The Journal* recently, but it did not present an analysis of what might reasonably be expected under the terms of the bill in the matter of pensions. The current article provides that analysis for the benefits of physicians, professional persons generally, and those interested in the pension plight of the self-employed.

On the basis of recent surveys by the United States Department of Commerce of the incomes of physicians, lawyers, and dentists, it has been estimated that the average monthly pension starting at age seventy that could be reasonably expected under this bill would be $208 for physicians, $146 for lawyers, and $140 for dentists. If the proposed past-service credits feature were adopted by the Congress the average expected pension starting at age seventy-five—not age seventy—for those now aged fifty-six would be $131 per month for physicians, $121 for lawyers, and $72 for dentists. The tax savings resulting from deferring the taxes to the low income retired years would probably not average more than one-fifth of these annuities.

As a result of his analysis, the Director of the Bureau of Medical Economic Research expresses the view that the loss in revenues to the Treasury Department will be moderate. They will be small in comparison with the amounts now being excluded by employers for the financing of approved pension plans for their employes. He also points out to those who labeled this bill a "rich man's" bill that under employer pension systems the amounts contributed by the employer are greater for the higher paid employes than for the lower paid employes. Most persons are well past forty years of age and approaching the peak earning period of their lives before they think seriously about setting aside some of their income for retirement purposes. This greater prospective use of the bill by older professional persons is a phenomenon of age rather than of higher income. For persons in the same age group Dickinson expresses the view that the propensity of the professional man and his wife to save for old age will probably be the major factor in determining their decision to exclude from current taxable income the maximum percentage of their earned income permitted under this bill. For these reasons it is apparent that the charge of critics that this is a "rich man's" bill are not well founded.—Editorial, *J.A.M.A.*, May 24, 1952.

PRINCIPLES, NOT PERSONALITIES

The 1952 Presidential campaign gathers steam with each passing day. In the excitement about favorite sons, "dark horses," and popularity polls, it is easy to be distracted from the significant issues of our day. Who is elected is important. But of even greater importance is the one basic issue:

Do we want our government to be the servant of the people? Or do we want it to be master over us?

Should we allow the Federal government in Washington to acquire more and more power? Or should we stand pat on the principles of our Constitution which specified that any powers not expressly given to federal officials were to remain with the individual citizens and their local governments?

Shall we permit Federal officeholders to install a system of compulsory, government-guaranteed "security?" Or shall we insist that personal responsibility for one's own welfare brings increased material well-being—a principle that America has proved to be the most effective that the world has ever known in the field of government?

Do we want taxes to go up and up, taking away from the wage-earner more and more of the fruits of his labor? Do we want corruption to continue destroying the people's faith in their public officials? Do we want inflation to so completely destroy the value of our medium of exchange that it is hardly safe to be thrifty?

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PRINCIPLES, NOT PERSONALITIES

(Continued from Page 818)

Do we want the Federal government to have such gross misconceptions of its "duty" that it completely separates the physician from his patient and subjects both to its advice and control regarding the care of the sick?

Shall our America be the land of opportunity, of individual freedom, of personal responsibility, or should this be merely a land of uneasy, forced security?

These are part and parcel of the fundamental issues in America today. These issues remain regardless of the individual or party in power. Experience has shown us that the growth of government in any field, once started, usually goes forward regardless of the party in power or the amount of resistance.

We know that the election or appointment of a man to public office does not endow him with wisdom or compassion. It can only endow him with power. It is this power that creates welfare states, socialist states, and dictatorships, not who is elected or how he is elected.

Unless we put the government back into the place assigned it by our ancestors as a servant of the people, we will miss the greatest opportunity of the coming election.—Editorial, *The Wisconsin Medical Journal,* May, 1952.

STATE MEDICINE GETS A SETBACK

A bill increasing payments to 4½ million old-age and survivor insurance beneficiaries under the social security program was beaten in the house, much to the surprise of the Washington correspondents, who expected the measure to have easy sailing in this election year. Brought to the floor under a procedure requiring two-thirds majority for passage, the vote was 149 for the bill and 140 against. It needed 193 votes of the 289 cast.

Opponents of the bill, mostly Republicans and southern Democrats, explained they were not against the proposal to increase benefits. Their opposition arose from a "sleeper" provision granting the social security administrator authority to appoint physicians to examine disability claimants.

The bill's opponents pointed out that this would put the government's foot in the door of socialized medicine. The first corps of politically controlled doctors would be organized, the first government medical regulations would be set forth.

The injection of this provision in an otherwise worthy piece of legislation was a trick. Now that the bill has been blocked, the Democrats are talking about letting it die so they can blame the Republicans in election speeches beamed at retired workers.

That phony issue may as well be disposed of right now. The reason that the bill required a two-thirds vote for passage was that it was brought up under a suspension of the rules, restricting debate and barring any amendments. Oscar Ewing and his socialized medicine gang thought that, even if their sneak play was detected, the house would swallow it rather than vote against the pension increase. If the Democratic majority doesn't bring up the bill under normal procedure, without the objectionable section, it will be they, not the Republicans, who are guilty of denying pensioners an increase.—Editorial, *Chicago Tribune,* May 24, 1952.

TAX FACTS

An interesting bit of research by the Council of State Chambers of Commerce shows that the high cost of running the Government cannot be met by "soaking the rich."

An individual with a taxable income of $100,000 a year now pays about $67,000 in taxes. There are so few incomes in the country which exceed $100,000 that, if the Government were to impose a 100 per cent tax on that portion of such incomes in excess of $100,000, it would net only $34 million a year above what it now gets. That sum is about enough to run the Government for three and one-half hours.

If the Government confiscated all individual incomes in excess of $10,000 a year, the additional tax revenue would amount to $3.1 billion, or enough to run the Government for two weeks under the proposed 1953 budget.

If Uncle Sam were to take all taxable income earned by individuals in excess of $6,000 a year, the extra yield would be less than $6 billion, or about enough to pay for half of the foreign aid proposed by the President for 1953.

Estimates of the Joint Committee on Internal Revenue Taxation show that if taxes are raised again, those earning $10,000 or less will pay 74.8 per cent of the increase.

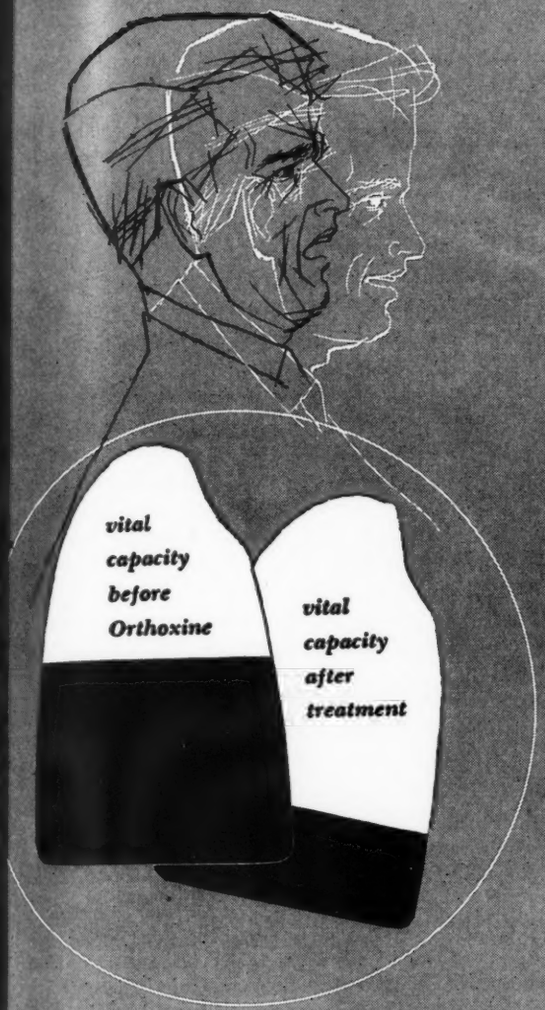
Since the Federal tax rates on large incomes now go as high as 92 per cent, little remains to be taken from that source.

Under 1915 tax laws, a family of four with a net income of $58,000 paid a Federal income tax of $1,000. Under 1952 laws, a $1,000 tax is levied on an income of $6,840.

When you realize that the Federal Government today employs 2,500,000 people at a cost of more than $666 million a month; that one of every five citizens receives some form of income from the Government; that $1 out of every $4 we earn goes for taxes to support the Federal Government and that about $1 of every $10 spent is being wasted, it's time to get mad.

We have twenty-nine Federal agencies lending money, twenty-eight handling welfare projects, sixteen in wildlife preservation, and fifty compiling statistics.

One agency has enough light bulbs to last ninety-three years, and another enough loose leaf binders to last 247 years. One bureau has twenty-four supervisors for every twenty-five employes.



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Federal Medicine

GENERAL EISENHOWER

In April we published a statement from Senator Lodge, the Eisenhower chairman, regarding the general's stand on socialized medicine. Since his return to America the general made the following statement. We are publishing it to be entirely fair:

Q.—I was told by a prominent physician in Washington that the doctors are being urged to oppose you because you are for compulsory health insurance. Are you for compulsory health insurance?

A.—Well, I am not going to answer too specifically, because what could be in a bill labeled compulsory health insurance? I am not so certain.

But I can tell you this: I am quite certain over the years that I was at Columbia, no one spoke out more than I did against the centralization of power in Washington, against bureaucratic government and submitting our lives toward a control that would lead inevitably to socialism, because, you see, beyond pure socialism, I believe, lies pure dictatorship, and you can't escape it.

Now, I do believe that every American has a right to decent medical care.

When I went to Columbia I found one thing: that medical education has become so expensive that it is embarrassing great universities that are privately supported and embarrassing them very badly—so badly that some of them almost in despair are turning to the Government for help to oppose that system.

I helped to organize and supported an organization of private citizens, insisting that we must in these private universities support medical education by private means, because if we didn't it would be the first step toward the socialization of medicine, and I am against socialization.

FSA SAYS PUBLIC "IS BECOMING MORE INSISTENT" ON NATIONAL HEALTH INSURANCE

The Federal Security Administrator says *the public is becoming "more insistent that a form of national health insurance become a reality"* and he adds: "My friends, you will get it." His prediction was made in an address to the New Jersey State Federation of Labor.

He told the labor convention: "But our work is far from done. The battle for security is only partly won. There are still big gaping holes in the fence we are building to protect your little bit of heaven. One of the biggest holes is the insecurity produced by illness . . . For the past few years we have been fighting to provide the people of this country with security against the catastrophe of illness. We have been advocating a simple, national health insurance plan, along lines similar to social security."

Then the FS Administrator went on to say: "The battle has indeed been acrimonious . . . The noble profession of medicine was traduced and the reputations of the physician became a dish rag of politics. The honest, decent medical practitioners were compelled under threat of expulsion to contribute two million dollars to a smear campaign . . . I doubt if the medical autarchy will be able to tax its members anew for another campaign against the health of the people. There is smoldering resentment among the rank and file of the medical profession. The honest, sincere, lovable practitioners do not wish to see their names befouled by the hucksters of Hippocrates . . ."

In the same speech the FS Administrator acknowledged that *"this country had made fabulous strides in health,"* that since 1932 life expectancy has increased ten years and that " we have virtually conquered the most infectious diseases."

DEFEAT OF HR 7800

Oppose Socialized Medicine. — American Medical Association officials have announced that the profession is not opposed in any way to increased benefits for social security beneficiaries, but is opposed to socialized medicine, and will oppose it in any form and in any bill or any type of legislation.

Following the defeat of H.R. 7800 the press romped all over the Republicans, loudly asserting they had voted against the aged when, in reality, everyone in the House knew the vote had been against socialized medicine. Indeed, the adverse vote was not wholly on party lines. Over 75 per cent of the votes against H.R. 7800 were cast by Democrats.

Enactment of H.R. 7800 would have opened the door to socialized medicine. The plot to sneak the measure through was one of the cleverest concocted so far by the Socialists. It was an extremely narrow escape from the inauguration of federal control over physicians and their patients.

FREE HOSPITALIZATION

Free hospitalization for all persons eligible for social security benefits, the recommendation made by the Federal Security Administrator is provided for in bills just introduced before Congress. The proposal calls for federal grants to states of

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FREE HOSPITALIZATION

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hospitalization funds in proportion to the number of social security beneficiaries. The states could enter into contracts directly with approved hospitals or with voluntary nonprofit health insurance plans such as Blue Cross. As noted in our previous newsletter the proposed program, by including dependents and survivors, would go much further than merely providing hospitalization for the aged.

BRITAIN SCALES DOWN SOCIALIZED HEALTH PLAN

LONDON—AP—Britain's socialized medicine program will be scaled down Sunday.

For the first time in four years, Britons will have to pay directly for some health services, such as prescriptions, dental treatment, false teeth and wigs.

Winston Churchill's government cut back the tax-supported program to save an expected $56,000,000 a year.

The hard core of the program is not destroyed, however, and Health Minister Ian MacLeod said in a speech "the government does not declare, and it is not part of conservative policy or philosophy, that charges must remain a permanent part of the national health service."

Socialized medicine was the most popular measure of the former Labor Government. Its principle has become widely accepted.

About 95 per cent of the people use the health service. About 95 per cent of the country's 11,000 dentists, 90 per cent of the 23,500 general medical practitioners and practically all the 16,000 druggists and 7,000 opticians participate.

The new charges include: up to $12.60 for false teeth, up to one pound $2.80 for a course of dental treatment, 14 cents for each prescription, $8.40 for surgical boots, $2.80 for surgical supports, and varying costs for a private room in a hospital for many cases.

There still will be no direct charge for a doctor's services, surgery, hospital care, or laboratory work. —*Detroit Free Press,* June 12, 1952.

SOCIAL SECURITY AND OLD-AGE ASSISTANCE

During the fiscal year ending June 30, 1951, total receipts amounted to $3,411,489,779.32—nearly $3.5 billion. What a bonanza the Social Security taxes have proved to be! In a single year, the Federal Government extracted from the people Social Security taxes amounting to three times as much as the entire annual cost of Government prior to World War I. The 1951 Social Security "take" just about equalled what it cost to run the Government each year in the golden twenties.

A mere $1,498,100,000 went to benefit payments, while $70,400,000 was spent on administration. Thus less than half of what was taken in was spent for beneficiaries; the remainder was immediately syphoned off through the "special issue" bonds.

Only 59 per cent of those who are eligible for OASI are actually receiving benefits. Ultimately only two-thirds of those who are eligible for benefits will actually receive them. Of 12,700,000 persons sixty-five and over last June, only about 3.5 million were receiving OASI benefits. *Only one aged person in seven benefits under OASI because of restrictive clauses in the law. This is the Administration's vaunted insurance program for the aged!*

FEDERAL LEGISLATION

Bills for a bipartisan commission to study existing public and private old-age and retirement benefits have been introduced in Congress. The sponsors of the bill maintain that the hundreds of federal, state, and local old-age and retirement programs are "failing to provide the aged of our country with the protection they need." If authorized by Congress, the Commission would have the responsibility of studying the character and amount of present benefits and plans, recommending changes in the federal laws with regard to private, local, state, and federal systems, and of estimating the cost of providing recommended increases in benefits, as well as methods to be used to finance the increased benefits.

* * *

Military Personnel and U. S. Public Health Service Doctors Receive Pay Increase.—Completion of Congressional action means a pay increase, probably retroactive to May 1, for all military personnel (including reserves and retired) and commissioned members of the U. S. Public Health Service. If President Truman signs the bill before June 1, the increases will appear on pay checks for May. The conference report was approved unanimously by both House and Senate (333 to 0 in House, also unanimously in Senate, but only six Senators present). *Base pay will be increased 4 per cent and housing and subsistence allowance 14 per cent.* It is estimated the annual cost will be $484 million.

* * *

Regulations and Rulings.—Federal Security Agency has issued the final standards for five varieties of bread—white, milk, enriched, whole wheat and raisin bread—specifying the ingredients allowed in each type. Chemical bread "softeners" are not approved, because, FSA says, they tend to deceive the consumer as to the age of the bread and they have not been tested sufficiently.

* * *

Wage Stabilization Board has placed paid sick leave benefits under jurisdiction of its Health and Welfare Committee. Formerly these were considered with other "fringe" benefits but under the new regulations all new

(Continued on Page 861)

265 ARMY MEDICAL SERVICE RESERVISTS INCLUDED IN SUPPLEMENTAL CALL TO ACTIVE DUTY

Two hundred and sixty-five officers of the Army Medical Service Reserve will be ordered into active military service in July, the Department of the Army has announced. This is in addition to the original call up of 290 officers made in March.

Included in the new group are 232 physicianss, twenty-five dentists and eight veterinarians. Quotas have been assigned to each of the six Army areas in the continental United States, as well as U. S. Army, Pacific, and U. S. Army Caribbean.

For the first time in the history of the Army Dental Corps, dentists with a Priority II rating will be called. This is due to the fact that the listing of officers available under Priority I has been exhausted.

Under the law, Priority I registrants are defined as those educated at Government expense and others deferred from service to pursue a medical or dental education, who spent less than ninety days on active service in World War II following their training. Priority II registrants differ only in that they have spent more than ninety days but less than twenty-one monthss on active service in World War II following their training.

The Army is selecting those with the least amount of creditable service first and no one with more than twelve months of previous service will be called. Physicians and veterinarians will continue to be selected entirely from the Volunteer Reserve, classified as Priority I.

ARMY TESTS NEW PLASTIC BAG TO REPLACE GLASS BOTTLE AS WHOLE BLOOD CONTAINER

New plastic bags may replace glass bottles as containers of whole blood for military use if current tests by the Army Medical Service confirm that the plastic holders facilitate transfusions and substantially reduce the bulk of shipments.

Major General George E. Armstrong, MC, Army Surgeon General, reports that the plastic containers have proved equally valuable in both field trials and hospital use. Blood packaged in the 6 x 8-inch bags occupies only one half the space required by glass bottles now in use and can be airdropped to troops in combat without breakage.

Physicians at Brooke Army Medical Center, Fort Sam Houston, Tex., and Walter Reed Army Medical Center, Washington, D. C., report arterial transfusions are easier and safer to give when whole blood can be forced into the patient's bloodstream by direct hand pressure on the plastic container. This eliminates the need for special apparatus to build up pressure with the attendant danger of air entering the system.

Determination of the practicality of the new containers for Army-wide use will be made after improved models have been evaluated at Brooke, Walter Reed and two Air Force and two Navy hospitals.

The bags are also used for collecting blood from donors at the test centers. Although they do not have the vacuum pull incorporated in the bottles, the plastic units can fill in eight to sixteen minutes with the aid of gravity and the donor's muscular efforts.

Air shipment of whole blood to Korea and other overseas areas will be greatly facilitated because of the small weight and bulk of the plastic containers compared to the glass bottles. Storage of the empty bags will require one quarter of the space occupied by the glass bottles.

Each bag comes collapsed around 75 cc. of anticoagulant, ready to receive blood from a donor. One type comes with donor tubing attached which may be used as a hanging device; a second has a measuring device on its side to indicate the amount of blood it contains.

FEDERAL CIVIL DEFENSE FUNDS USED LARGELY FOR MEDICAL PURPOSES

Approximately *70 per cent* of all federal money spent on civil defense is going for medical purposes, principally matching grants to states for local medical stockpiling and all-federal regional stockpiles. This breakdown of Federal Civil Defense Administration activities is contained in Administrator Millard Caldwell's annual report, covering the first full year's operations of FCDA. So far FCDA appropriations for all purposes have totaled about $100 million. Of this, $50 million is earmarked for all-federal medical purchases. $20 million will be used either for federal medical purchases or matching grants to states.

By next June, the report estimates that about $90 million in medical supplies will have been procured or will be on order, the extra $20 million to come from non-federal sources.

During 1951, FCDA prepared and sent to regional, state and local civil defense directors specifications for about 200 individual medical items. Using these specifications, state and local civil defense organizations may do their own ordering, or order through FCDA, which makes use of the Armed Services Medical Procurement Agency for purposes of co-ordination and economy.

The report says that within the next year a total of

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FEDERAL CIVIL DEFENSE FUNDS USED LARGELY FOR MEDICAL PURPOSES

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fifty-eight regional warehouses will be available for stockpiling of federal supplies, including engineering as well as medical. In federal warehouses, a system of "unitizing" is used, and FCDA officials are encouraging state and local officials to employ a similar technique. On this the report says, "Supplies must be warehoused in such a way that they are immediately available at time of emergency. This requires 'unitizing.' Instead of all items of a given type, such as surgical instruments, being stored in one area of a warehouse, items making up a unit are stored together. For example, present plans call for storage of medical supplies and equipment in units necessary for a 200-bed emergency hospital." States are being urged to store their own supplies in units sufficient to care for 1,000 casualties.

In case of an emergency, the local community will have to depend on its own medical supplies and services for the first few hours, awaiting the arrival of medical units from the nearest federal regional warehouse.

On the federal level, plans are being made for exchange of perishable medical supplies with other government agencies, while states expect to rotate their own perishable items with state hospitals and other institutions.

ARMY SELECTS SENIOR MEDICAL STUDENTS FOR INTERN PROGRAM

Appointment of 146 senior medical students for the Military Intern Program of the Army Medical Service was announced by Major General George E. Armstrong, Army Surgeon General.

The Program, scheduled to get under way July 1, provides that medical students, upon graduation, can be commissioned as first lieutenants in the Medical Corps Reserve and serve their internships in Army hospitals.

Representing fifty-one medical schools and colleges, the students will be assigned to the ten Army teaching hospitals in the United States and to Trippler Army Hospital in Hawaii. Ninety-eight of those selected, including the three women in the group, have previously served in the armed forces.

Seventy-five per cent of the students applying have been assigned to the first hospital of their choice. Of those appointed in this list four are to go to Percy Jones General Hospital at Battle Creek.

The following Michigan students have been accepted, and assigned as indicated: Charles M. Ebner, Grosse Pointe—Letterman; Loyal W. Jodar, Detroit—Fitzsimons; William H. Owen, Detroit—Walter Reed; William E. Rush, Detroit—Letterman; Jack C. Todt, Detroit—Trippler.

Those being assigned to Percy Jones are: Walter H. Hanna, Breckinridge, Texas; Daniel S. Snow, Rochester, Pa.; Estil Y. Strawn, St. Joseph, Mo., and Joseph A. George, Jefferson, La.

WAR MANPOWER COUNCIL URGES MILITARY DEFERMENT THROUGH ONE YEAR OF RESIDENCY

The War Manpower Council, a citizens' organization financed by the Ford Foundation, has recommended that physicians be deferred from military service until completion of one year of residency training. The Council's report, *Student Deferment and National Policy*, lists this among its 14 recommendations made to Defense Department, Selective Service and other government agencies.

Currently, medical students are deferred through one year of internship, by which time they are subject to the Doctor-Draft law.

The Council also suggested that: (a) deferment of young fathers be ended, (b) present student deferment on the basis of aptitude tests and class standing be continued, (c) the military make the best possible use of its own scientific and technical personnel by turning many jobs over to civilians and (d) the military check into its procurement policy to see if it is using too great a proportion of scientific and engineering school graduates as line officers.

Neither Defense Department nor Selective Service has commented on the recommendations but both are studying the proposals.

COST OF LIVING

The following set of figures should be in the mind of every doctor. During the last decade the cost of living went up 69 per cent. The total hospital bills went up 67 per cent. Many of these, of course, depend upon the cost of food and wages. The cost of prescriptions only went up 37 per cent and cost of doctors' fees only went up 38 per cent. These figures are from the Department of Labor. We should all be able to quote them, and we should do so frequently.

In ten years the cost of medical care has not risen nearly as much as the cost of living:

Cost of living	Up 69%
Hospital bills	Up 67%
Cost of prescriptions	Up 37%
Doctor's bills	Up 38%

Hospital, surgical and medical insurance coverage is as follows:

Hospital insurance	Over 75 million people
Surgical insurance	About 55 million people
Medical insurance	Over 20 million people

RELATIVE VALUES

Many times we hear the remark that large corporations pay their executives tremendous salaries and bonuses. One of the radio commentators Tuesday evening, April 22, 1952, in reporting the hearings about the steel seizure, mentioned the testimony of Richard Fairless, President of U. S. Steel, who in 1951 was paid about $260,000, an increase of 80 per cent over his pay in 1940. However, taking into consideration the changes of income tax assessments, instead of getting more money he is actually being paid 4 per cent less than in 1940—that is, his actual "take home pay" is 4 per cent less.

The JOURNAL

of the Michigan State Medical Society

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOLUME 51 JULY, 1952 NUMBER 7

Disseminated Coccidioidomycosis

By Henry A. Chapnick, M.D.
Detroit, Michigan

THE PREVALENCE of a respiratory infection associated occasionally with erythema nodosum has been known to California physicians for many years as "Valley Fever," "Joaquin Fever" and "California Fever." It wasn't until 1937 that Dickson and Pierson[3] of Stanford University elucidated the relationship of this respiratory infection with coccidioidal granuloma. It had been thought until then that coccidioidosis, by which term only the disseminated or granulomatous type was meant, was invariably fatal. One of their patients, a laboratory worker, acquired a coccidioidal infection while studying an old culture of coccidioides immitis. To their surprise, the patient got well. Subsequently, it was found that the majority of residents in endemic regions are skin sensitive to coccidioidin, an extract of coccidioides immitis. Thus Gifford and her associates[7] tested 2,718 children in Kern County, California, and found over 50 per cent of them skin sensitive. Out of the relatively large number of patients having this "Valley Fever," a few develop pulmonary lesions, consisting of cavitation, pneumonitis, mediastinal widening and pleural effusion. Most of these do well. It has been estimated that one out of 500 cases of coccidioidomycosis will develop the disseminated type. Thus out of "several thousand"[8] men who were exposed for two weeks to dust in an endemic area, only seventy-five came down with the primary pulmonary disease. Of these, only three developed cavities, and all were reported as cured. In one of these, blood transfusions from a donor who had recovered from coccidioidomycosis was suggestively a factor.

It is the disseminated type which has aroused great interest in recent years. Other endemic foci than the Joaquin Valley are known. Cases have been reported from San Bernito County, California, southern Arizona,[10] southern Utah, western Texas[2] and northern Mexico.[9] Other known foci are Argentina,[11] Italy[12] and the Hawaiian Islands.[5] It has been suggested that other arid zones of the globe, such as northern Africa, the Near East and Australia, deserve closer scrutiny. That the incidence rate of disseminated coccidioidomycosis among troops who were trained in the southwest United States was small is indicated by the fact that only ninety-five cases of disseminated coccidioidomycosis were reported.[6] Because of the slow progress of the disease in some patients, the disease may not become manifest for months or even several years.

The granulomatous form of this disease was first described by Posada and Wernicke[17] in 1892. Rixford[13] described the first case in the United States in 1894. Since then, until 1939, 578 cases, with 278 deaths, have been recorded. The disease is known to affect cattle,[1] sheep, dogs and rodents,[4] in fact, rodents are thought to serve as a reservoir for the causative organism.

The causative organism is the diphasic fungus coccidioides immitis, which should not be confused with the protozoan coccidium resembling coccidioides immitis. It was because of this resemblance that Posada felt the organism to belong to the coccidia group and accounts for the name of the disease. From lesions of the disseminated type, as well as from sputum of the primary pulmonary type, spherules with double refractile walls can be isolated. These spherules multiply by endosporulation. In time, the capsule ruptures and endospores are liberated. The endospores in turn form

mycelia. The mycelia segment and break into small particles, chlamydospores. Pus inoculated on culture media or left in a container will form a mould containing myriads of chlamydospores. It is in this latter form that the coccidia are extremely infectious.

The similarity between tuberculosis and coccidioidomycosis is pointed out by Smith.[16] Thus, both diseases are acquired through the respiratory tract, both develop allergic sensitization, in both the sensitization disappears when the disease becomes disseminated, both produce pulmonary calcification, both show protean clinical forms. It should be pointed out, however, that, whereas in tuberculosis pulmonary cavitation is not felt to be a primary infection, in coccidioidomycosis it may be, and that while the preponderance of opinion is that exogenous re-infection is the cause of pulmonary tuberculosis cavitation, disseminated coccidioidomycosis is felt to be due to endogenous re-infection.

With the exception of the gastrointestinal tract, case reports have detailed involvement of every organ in the body. Pulmonary cavitation and pleural effusion subsequently proved to be due to coccidioidomycosis have been treated for tuberculosis. The disease has been confused with lymphoblastoma because of the mediastinal widening. Peritonitis,[15] arthritis[14] and osteomyelitis have been described. Of interest is the coccidioidal granulomatous meningitis that mimics brain and spinal cord tumors. The following three cases demonstrate the difference in the rate of progression of this disease, the varied clinical manifestations and the diagnostic problems involved.

Case 1.—A twenty-nine-year-old soldier acquired a protracted attack of "flu" in October, 1943, immediately following maneuvers in Arizona. In the next six weeks he lost 30 pounds of weight. Examination then was negative, but a chest x-ray in January 1944 revealed a widened mediastinum which, in the presence of an equivocal coccidioidin skin test and absent tubercle bacilli in the sputum, was interpreted as a mediastinal lymphoblastoma. A blood count at that time showed 10,000 to 18,000 white cells, with an eosinophilia ranging from 3 to 27 per cent. The sedimentation rate was 40 mm. per hour. In February, 1944, the patient began complaining of headaches. He had hyperactive reflexes and tremors of the fingers of both hands. Spinal fluid studies revealed a total cell count ranging from 51 to 320 per cm., with a relative lymphocytosis. Spinal fluid sugars ranged from 13 to 33 mg. per cent, protein varied from 74 to 1,618 mg. per cent, colloidal gold 5555555555. Spinal fluid cultures were negative for coccidioides immitis. Virus neutralization studies were negative for lymphocytic choriomeningitis, Western equine encephalomyelitis, and the St. Louis type encephalitis. Skin tests for coccidioides were negative. The chest x-ray became normal.

Gradually the headaches became more severe. In July, 1944, he began complaining of a sharp pain in his neck, radiating to both arms. He began showing atrophy of the shoulder muscles, neck rigidity and a positive Kernig. In August the Queckenstedt was noted to be positive. The neck pain became more severe. A myelogram showed complete block at the level of the fifth cervical vertebra. Papilledema became apparent. A laminectomy was done in October, 1944. At operation, the dura was definitely adherent to the arachnoid and the latter to the pia. The arachnoid was studded with multiple pearly granules resembling tuberculosis. The fourth and fifth roots were densely incarcerated in the fibrous tissue. On the right side of the cord, about the fifth cervical level, several small cysts containing about 1 cc. of fluid were present. The arachnoid in this region was released as much as was possible. Following the operation, this patient was somewhat relieved of his pain but the paralysis progressed until the upper extremities and chest muscles became completely paralyzed and atrophied. The above findings were associated with absent reflexes of the upper part of the body, absent abdominal reflexes and loss of vibratory sensation. Then his lower extremities became spastic, there was a persistent patellar and ankle clonus and a bilateral Babinski. The patient received sulfadiazine, penicillin and potassium iodide, without producing any change in the onward progression of the disease.

Granulomatous tissue was removed from the base of the brain, showed typical coccidioidal spherules. A complement fixation test, done in Dr. Charles E. Smith's laboratory at Stanford University, was positive for coccidioidomycosis. He gradually became completely paralyzed, developed renal stones and a kidney infection and finally died of pneumonia.

Postmortem examination revealed involvement of the brain, lungs and long bones in a granulomatous process typical of coccidioidomycosis.

Case 2.—A thirty-five-year-old soldier began having severe headaches in August, 1944. This, however, did not prevent him from participating in the Normandy campaign. This patient trained in the Mojave Desert from November, 1943, to January, 1944, at the end of which time he had a severe cold, for which he was hospitalized for ten days. He had no further trouble until August, 1944. In fact, it was not until after he was hospitalized for a knee injury in December, 1944, that he called the medical officer's attention to headaches and defective vision. At that time the patient showed definite papilledema. Spinal fluid examination revealed a pressure of 400 to 440 with no evidence of blood, a cell count of 400 to 690, initially showing 86 per cent lymphocytes, 3 per cent polymorphonuclear cells and 11 per cent eosinophiles, a total protein ranging from 190 to 240 mg. per cent, and a spinal fluid sugar varying from 15 to 40 mg. per cent. Inoculation of the spinal fluid into guinea pigs and spinal fluid cultures were negative. Spinal fluid

sediment revealed several bodies very suggestive of coccidioides immitis. An encephalogram showed a right internal hydrocephalus and was interpreted as consistent with a diagnosis of chronic arachnoiditis. The patient was transferred to another general hospital in the United States, where it was thought that the patient had a pineal tumor and was sent to Percy Jones General Hospital for x-ray therapy.

On admission to Percy Jones General Hospital the patient no longer had any complaints. His headaches disappeared following the encephalogram done in the previous hospital. Examination revealed a well-developed and apparently healthy man, a papilledema of three diopters on the left and four diopters on the right, an absent right knee jerk and bilaterally decreased ankle and left knee jerks. Coccidioidin test 1:100 was 1-plus; spinal fluid findings did not differ from the one done overseas except that the gold curve was 0000000000. The sedimentation rate was 5 mm. for sixty minutes, and the blood count and urine examinations were negative. A complement fixation test was done at Dr. C. R. Smith's laboratory and was positive 1:10. It was Dr. Smith's opinion that this low titre, in the absence of a paretic gold curve, suggested that the infection was not progressive. The patient was given penicillin, 40,000 units every three hours, for 120 doses, without in any way affecting his vision. In fact, the papilledema and blind spots slowly progressed. To save the patient's vision, it was suggested to him that a ventriculostomy be done, but because of the patient's sense of well being, he preferred to "let sleeping dogs lie."

Case 3.—A twenty-six-year-old Negro soldier came on duty from Alabama to Fort Huachuck, Arizona, in December, 1944. In October, 1944, he began to cough, began to have some dyspnea and a sense of pressure in the chest. A nodule appeared on the lower portion of the right side of the neck anteriorly. He gradually lost weight and strength. He was hospitalized early in February, 1945, and a chest x-ray at that time revealed accentuation of the hilar shadows. Another chest x-ray taken on February 26, showed mediastinal widening and was interpreted as a lymphoblastoma because of a negative tuberculin and coccidioidin tests. A biopsy of the right supraclavicular node showed granulation tissue with heavy infestation with coccidioides immitis. White blood counts done during February showed a cell count varying from 3400 to 12,000 and an eosinophilia of 6 per cent on one occasion. From March until July, the white count varied from 11,700 to 15,100, with no eosinophilia. On July 3, the white count was 15,500, polymorphonuclear cells 66 per cent, lymphocytes 15 per cent, and eosinophiles 19 per cent. Complement fixation test done by Dr. C. E. Smith of Stanford University in March was positive 1:64, and a third one was 1:256. Precipitin tests were negative. The patient was transferred to Percy Jones General Hospital on July 29, 1945. Examination revealed a markedly emaciated Negro, acutely ill, complaining of severe pain in his back and over both iliac bones. He had a fecal odor about him, even though he was not incontinent. He had fluctuant masses about 9x10 cm. in diameter over both sacro-iliac bones, over the right scapula and a somewhat smaller one over the left ninth rib anteriorly. There was a draining wound in the right supraclavicular area where a biopsy had been done four months earlier. There were many fine râles throughout the right chest. The abdomen was rigidly held so that examination was not satisfactory. Material from one of the fluctuant masses revealed a pure culture of coccidioides immitis. X-ray examination revealed no evidence of bone destruction until June 7, when a destructive process was noted in the left ninth rib in the anterior axillary line. On the 23rd of June, involvement of the crests of both iliac bones and left scapula was noted. The patient ran a low grade fever, complained bitterly of pain in the joints and abdomen, and died on August 6, 1945.

The autopsy showed draining sinuses originating in both clavicles, ribs and in the pelvic bones. Necrotic material could be scooped out of the iliac bones. There was also diffuse involvement of his lungs.

Discussion

These three cases illustrate the marked difference in the rate of progress of this disease. In Case 2 there were no symptoms until eight months after exposure. While his complaints were relatively mild, he had abundant objective evidence of cerebral involvement. His low complement titre and normal sedimentation rate suggested that the disease process progressed rather slowly. In contrast is the third patient who had evidence of disseminated coccidioidosis four months after the initial exposure and progressed on an inexorable course until he died of the disease ten months from the time of exposure. Case 1 represents a rate of progress that is intermediate between Cases 2 and 3.

Case 2 would also tend to corroborate the view of those who hold that re-infection is endogenous. Following his exposure in the Mojave Desert and the respiratory infection that followed, the patient left that endemic area for the battlefields of France. He was asymptomatic for eight months, at the end of which time he began complaining of headaches. During the asymptomatic interval, the only sources of re-infection were his own latent foci. That the patient might have had meningeal involvement even at the time he left the Mojave Desert, but that the process was very slow, is clinically not probable though it cannot be definitely excluded.

Mention has already been made of the manifold clinical forms of this disease. This is further illustrated by the three cases here reported. In each one the absence of coccidioidin skin sensitivity was accepted as evidence against disseminated coccidioidomycosis. Important as this test is in the

diagnosis of the primary form, it does not exclude the disseminated type; indeed, its very absence may be taken as evidence of dissemination, providing there is other collateral evidence of a coccidioidal infection. The presence of pulmonary cavitation and the persistent absence of tubercle bacilli in the sputum should guard one against a hasty diagnosis of tuberculosis. A careful search for coccidioidal spherules should be done. The presence of an eosinophilia during the course of an obscure ailment with fever in a patient who was in an endemic area should strongly suggest coccidioidomycosis. A positive complement fixation and preciptin test would be confirmatory.

In both Cases 1 and 2, we noticed spinal fluid leukocytosis, low spinal fluid sugar and a markedly increased protein. These findings are not specific for coccidioidomycosis, and have also been found in torulosis involving the meninges. We do wish to emphasize, however, the spinal fluid eosinophilia. Cases 1 and 2 showed it on several occasions, especially after we began looking for it. In only one other case report is this finding mentioned, but its possible clinical significance was not emphasized. In view of the granulomatous character of the meningitic lesion, one might expect spinal fluid eosinophilia in such infections as torulosis and blastomycosis of the meninges. A differential count of the spinal fluid may thus direct the clinician to a diagnosis of a meningeal granuloma.

Lymphoblastoma has at times been a stumbling block, especially in the primary type. Knowledge of recent exposure to a coccidioidal infection, a positive sputum, a positive coccidioidin skin test, rapid changes over a short period of time and the mediastinal appearance of the lesion, and biopsy, should aid in making the correct diagnosis.

There is considerable confusion in the literature in regard to the nomenclature of this disease. Dixon rightly suggested that a distinction be made between the primary and the disseminated type. In the primary type the respiratory tract is involved in varying degrees of severity. Other organs are involved only if dissemination occurs. It is therefore a paradox in terms to speak of primary meningeal coccidioidomycosis. If it is primary, it is not meningeal; and if it is meningeal, it is not primary.

The term coccidioidal granuloma has been used interchangeably with disseminated coccidioidomycosis. While it is true that all coccidioidal granulomas are of the disseminated type, not all types of disseminated coccidioidomycosis manifest themselves as granulomas. The necrotic character of disseminated coccidioidomycosis is well illustrated in Case 3 herein reported. We therefore suggest that the term "primary" and "disseminated" coccidioidomycosis be used and that the term granulomatous be used only if clinical manifestations warrant it.

Summary

1. Three cases of disseminated coccidioidomycosis are reported, two with cerebral involvement and one with widespread necrotic manifestations.

2. Eosinophilia of the spinal fluid is suggested as a possible diagnostic aid in diagnosis of meningeal granulomatous coccidioidomycosis.

3. The clinical mimicry of this disease of lymphoblastosis, tuberculosis and brain tumor is demonstrated.

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Annular Pancreas

Report of a Case

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ANNULAR PANCREAS is a developmental or congenital anomaly in which a firm ring of grossly recognizable and apparently normal pancreatic tissue completely encircles the descending or second portion of the duodenum and is continuous with the head of the pancreas, without demarcation. This anomaly frequently produces no symptoms, the presence of annular pancreas being an incidental finding at autopsy. In surgical cases recorded, the second portion of the duodenum embraced by the encircling pancreatic ring is constricted, causing clinically partial duodenal obstruction. Dilatation and hypertrophy of the proximal duodenum and frequently of the stomach will then result (Fig. 1).

Abnormal Anatomy

The annular process arises from the dorsal portion of the head of the pancreas where it is thickest (0.5 to 2.5 cm.) and widest (1.0 to 4.5 cm.). The ring progresses to the right of the greater curvature of the second portion of the duodenum, gradually tapering in dimension, crossing the anterior surface to fuse with the uncinate process.

The annular pancreas cannot be distinguished histologically from the normal pancreas, as it possesses islets of Langerhans, acinar glands and a duct system with a main channel and tributaries. The principal duct of the ring formation arises anteriorly and courses from left to right with increasing caliber, through the ring of pancreatic tissue surrounding the duodenum, to the head of the gland posteriorly, where it usually passes posterior to the common bile duct and opens into the main pancreatic duct of Wirsung (Fig. 1).

In some autopsy specimens the united annular and duct of Wirsung may have no connection with the dorsal anlage duct that drains the body and tail of the pancreas. The duct of Santorini remains intact and serves as the main pancreatic duct

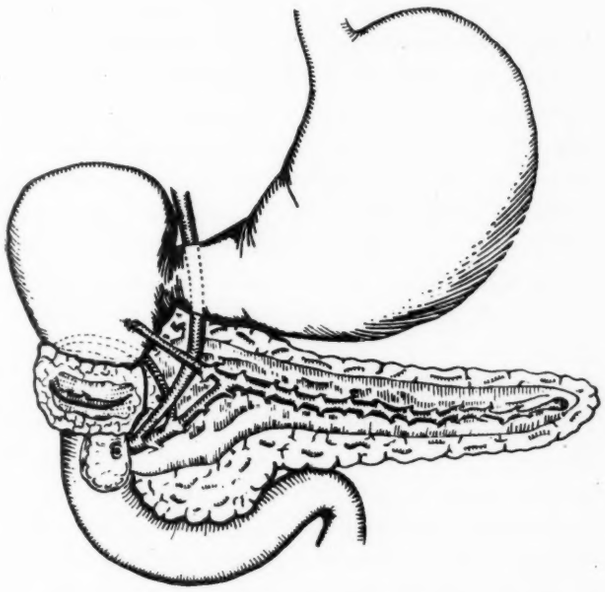

Fig. 1. Diagrammatic drawing of the more common findings in a case of annular pancreas. Note the large dilatation of the first portion of the duodenum with the ring portion encircling and constricting the second portion. The pancreas has been dissected to expose the duct system more commonly reported.

emptying into the duodenum at a normally situated papilla minor.[21] The duct of the annulus may empty into the common bile duct independent of either pancreatic duct.[8,27]

Embryology

Normally, two outpouchings from the entodermal lining of the duodenum can be noted in the human embryo of 3 to 4 mm. One bud pushes out from the dorsal wall into the dorsal mesentery just proximal to the hepatic diverticulum. This dorsal anlage grows across the body toward the left, until it reaches the spleen, giving rise to the body, tail and the ventral portion of the head of the adult gland.

The ventral pancreatic bud appears in the inferior angle between the gut and hepatic diverticulum and may be more or less bi-lobed, left and right. The ventral bud remains smaller and its short ventral duct is carried away from the duodenum by the lengthening common bile duct from which it then arises directly. Unequal growth of the duodenal wall, rotation of the stomach and duodenum with elongation of the bile duct to the

Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

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right brings the ventral pancreas up into the dorsal mesentery to approach and ultimately fuse with the dorsal pancreas. The ventral pancreas then forms the dorsal portion of the head and more or less of the uncinate process of the pancreas. The tip of the ventral pancreatic duct unites and anastomoses with the main stem of the dorsal duct. This united duct is then known as the main pancreatic duct of Wirsung which empties into the duodenum at the ampulla of Vater, beside or in the common bile duct. The remaining proximal portion of the dorsal pancreatic duct may atrophy, but usually persists and opens into the duodenum above the ampulla of Vater and is recognized as the accessory pancreatic duct of Santorini.

The embryology or origin of the annular pancreas has been thoroughly discussed by McNaught,[21] Howard[15] and Cunningham.[8] These authors quote freely from the reports of earlier investigators, especially Lecco.[16] In summary, the annular ring of pancreatic tissue is a persistence of the left half of the ventral anlage. The tip remains fixed to the duodenal wall in an anterior position and becomes stretched around the right side of the duodenum upon migration of the remaining portion of the ventral pancreas.

McNaught[22] and Cunningham[8] describe a method of injection and visualizing the duct system in autopsy specimens and urge that all specimens be so studied and reported.

Incidence

In 1933, McNaught[21] compiled forty cases of annular pancreas, of which thirty-three were autopsy or anatomical reports and seven operative case reports. Since then there has been added to the literature an additional six autopsy and twenty-one operative case reports, for a total of sixty-seven cases.

Recently, Payne[24] in a surgical review of annular pancreas tabulated eighteen operative case reports. To this list should be added ten additional surgical cases: the single cases of Llorco,[19] Markowicz[20] and Haden,[14] three cases of Ravitch[25] and two each of Conroy[7] and Glover.[11]

Sex and Age Incidence.—Sex: Of the total sixty-seven surgical and autopsy cases reported, thirty-nine were males, fifteen females and no sex recorded in thirteen cases.

Age: In the reported surgical cases, seven were within the newborn period, one three and one-half years and the remainder were adults from nineteen to seventy-four years old.

Clinical Findings

In almost all twenty-eight cases submitted to surgery, the patient presented signs and symptoms of acute or chronic duodenal obstruction. This obstruction resulted from the annular pancreas causing constriction of the second portion of the duodenum, with pronounced dilatation in the first portion. Other associated lesions have been described: benign gastric ulcer on the lesser curvature,[1,3,9] chronic interstitial pancreatitis,[4,20] hemorrhagic pancreatitis,[2] duodenal ulcer,[7,19,20] obstructive jaundice,[4,25] and dilatation with hypertrophy of the stomach in ten cases. Cases reported in the newborn have frequently demonstrated other congenital anomalies[11,13,25] (third case).

X-Ray Examination

Upper gastrointestinal x-ray study was reported in twenty-one cases. All reports gave an impression of partial or complete duodenal obstruction of the second portion, and in fourteen cases an associated dilatation of the first portion. In four cases the proximal duodenum was so dilated that it was interpreted roentgenologically as the dilated pyloric end of the stomach[7**,15,23,25**]

The causes of the duodenal obstruction was variously ascribed to diverticulum,[7*,15,27,28] stenosing duodenal ulcer,[3,19,20,23] adhesions,[7**,30] malignancy,[9] aberrant vessels,[24] diaphragm,[25**] "congenital,"[5] atresia,[25***] possible annular pancreas,[4,25*] definite annular pancreas,[14,17] and unknown,[1,12,13]

Treatment

The surgical procedures available and used to alleviate the acute or chronic duodenal obstruction were three: (1) direct attack on the constricting ring, (2) a short-circuiting anastomosis around the obstruction, (3) a combination of the preceding two (Table I).

Direct Attack on the Constricting Ring.—In eight cases the constricting ring was either divided or resected. Four patients[12,14,17,24] had an uneventful recovery, but all have continued with a low-grade duodenal obstruction without further

*First case in reference cited.
**Second case in reference cited.
***Third case in reference cited.

TABLE I. CASES OF ANNULAR PANCREAS TREATED BY OPERATION

Ref. No.	Reported by	Sex Age	Operation	Result	Remarks
11	Glover and Barry, 1949, case seven	Female 5 wks.	Partial resection or division of the ring.	Recovery, but continued vomiting.	Re-exploration in 4 days, gastrojejunostomy gave relief.
12	Goldyne and Carlson, 1946	Male 26 yrs.	Same	Symptomatic cure.	Post-op. X-ray: Persistent gastric and duodenal residue.
14	Haden 1950	Male 3½ yrs.	Same	Recovery, but occasional complaint of abdominal pain.	Post-op. X-ray: Slight dilatation of first portion and partial persistence of the defect in the second portion of duodenum.
15	Howard 1930	Female 46 yrs.	Same	Recovery, pseudo-cyst developed.	Incision and drainage of pseudo-cyst.
17	Lehman 1942	Male 23 yrs.	Same	Recovery, but persistent symptoms of obstruction.	Post-op. X-ray: Persistent deformity of the duodenum.
18	Lerat 1908	Female 46 yrs.	Same	Recovery	Pancreatic fistula closed spontaneously.
24	Payne 1951	Male 32 yrs.	Same	Recovery, but developed ulcer symptoms.	Post-op. X-ray: Dilated second portion of duodenum with retention.
25	Ravitch and Woods, 1951, first case	Male 67 yrs.	Same	Recovery, but symptoms recurred.	Re-exploration revealed scar tissue over excised ring area causing obstruction. Ant. Duodenojejunostomy for relief.
7	Conroy and Woelfel, 1951, first case	Male 30 yrs.	Partial resection of the ring plus exploratory duodenotomy of the first portion.	Cured	Redundant portion of duodenum was resected.
4	Brown, Bingham, Cronk, 1948	Female 53 yrs.	Same	Died	Sub-diaphragmatic abscess, duodenal fistula. Post. gastroenterostomy on the 22nd post-op. day.
30	Zeck 1931	Female 31 yrs.	Partial resection of the ring plus Heincke-Mikulicz plastic enlargement of constricted duodenum.	Recovery	Small pancreatic fistula healed spontaneously.
5	Burger and Aldrich, 1949	Female 4 days	Same	Died, 9th post-op. day.	Developed bile stained wound drainage.
29	Vidal 1905	Male 3 days	Gastroenterostomy	Cured	Associated congenital atresia of duodenum.
28	Truelson, 1940 second case	Male 35 yrs.	Same	Cured	Included duodenotomy.
7	Conroy and Woelfel 1951, second case	Female 26 yrs.	Same	Cured	Developed intestinal sprue.
3	Brines 1931	Male 44 yrs.	Same	Died, 16th post-op. day of respiratory infection.	Annular pancreas first recognized at autopsy.
10	Dos Santos 1906	Female 26 yrs.	Same	Died, 9th post-op. day of respiratory infection.	Same.
26	Smetana 1928	Male 74 yrs.	Same	Died, immediately post-op.	Same.
2	Brines 1930	Male 35 yrs.	Exploratory laparotomy and drainage.	Died, immediately post-op.	Annular pancreas first recognized at autopsy. Marked hemoperitoneum and pancreatitis.
19	Llorca and Barrios 1950	Male 19 yrs.	Peon-Bilroth I gastric resection.	Recovered	Post-op. X-ray: Persistent narrowing of the duodenum.
25	Ravitch and Woods 1951, third case	Male 6 days	Gastroduodenotomy	Cured	Marked congenital deformities of viscera and mesenteries.
13	Gross and Chisholm 1944	Female 3 days	Duodenojejunostomy	Cured	Incomplete rotation of colon.
25	Ravitch and Woods 1951, second case	Female 3 days	Same	Cured	None.
11	Glover and Barry 1949	Female premature 2½ lbs.	Same plus division of ring.	Died, 4th post-op. day.	Stenosis of duodenum.
9	Custer and Waugh 1944	Male 74 yrs.	Sub-total gastric resection with gastrojejunostomy.	Cured	Associated benign gastric ulcer.
1	Baker and Wilhelm 1950	Male 59 yrs.	Same	Cured	Associated benign gastric ulcer.
23	Ohlmacher and Marshall, 1950	Male 27 yrs.	Same	Cured	Huge dilatation of the duodenum, pylorus and stomach.
20	Markovitz and Dionisi, 1950	Male 41 yrs.	Same (partial resection of ring.)	Cured	Associated perforating duodenal ulcer.
	Bailey and Bovill 1951	Male 26 yrs.	Same	Cured	Annular pancreas encircled both first and second portions of the duodenum.

treatment. In a five-week-old infant, dividing the encircling ring of pancreatic tissue failed to relieve the duodenal obstruction. It was necessary on the fourth postoperative day to re-explore and bypass the obstruction by gastrojejunostomy.[11] One patient[25]* developed a postoperative pancreatitis and obstruction due to fibrotic tissue replacement of the resected ring. This later required anterior duodenojejunostomy for relief of the obstruction. Another case[18] showed a transient pancreatic fistula that closed spontaneously. The remaining patient[15] developed a pseudocyst that required incision and drainage.

*First case in reference cited.

Resection of the Ring, Plus Exploratory Duodenotomy of the Proximal Portion Was Reported in Two Cases.—One patient healed without incident.[7]* In the second case[4] annular pancreas

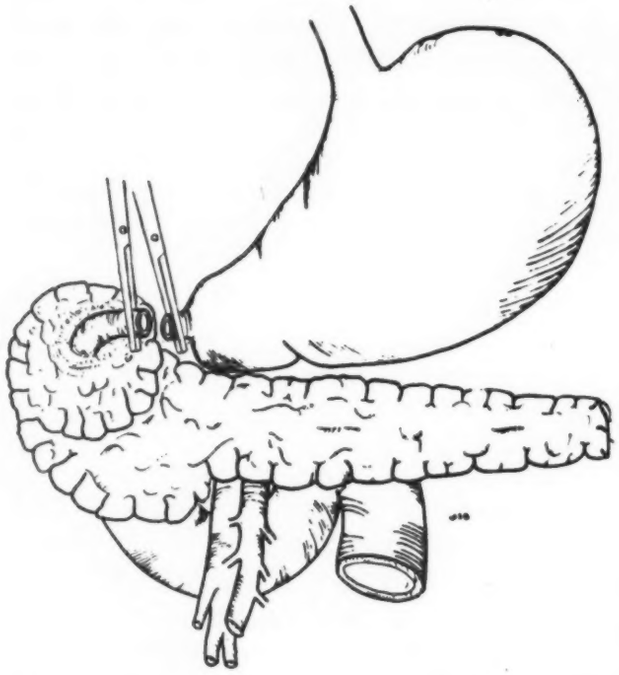

Fig. 2. Diagrammatic drawing of the case reported by the authors of an annular pancreas encircling the first and second portions of the duodenum. Note the hypoplastic duodenum uncovered by dissection of the pancreas.

was not recognized and cholecystectomy failed to give relief of her symptoms. Four weeks later, exploration revealed the annular pancreas, which was resected, plus duodenotomy and common duct exploration. On the twenty-second postoperative day a duodenal fistula was treated by posterior gastroenterostomy; the patient expired.

Resection of the Ring, Plus Plastic Enlargement of the Narrowed Duodenum.—Resection of the ring alone, in two cases, failed to relieve immediately the narrowed duodenum and a Heincke-Mikulicz plastic procedure was done. One case[30] healed without incident, except for a small pancreatic fistula that closed in a few days; while the second,[5] a newborn, developed a bile-stained wound drainage and expired on the ninth postoperative day.

Short-Circuiting Anastomosis.—Short-circuiting anastomosis around the duodenal obstruction has been accomplished by either a (1) gastrojejunostomy, with or without gastric resection, (2) duodenojejunostomy, or (3) duodenogastrostomy.

Gastrojejunostomy Was Employed in Six Cases.—The first surgical case recorded (Vidal[25] in 1905) in a newborn infant, with an associated atresia of the duodenum, was successfully treated by gastroenterostomy. Two additional successful cases in adults are noted.[7**,28]

Respiratory infection resulted in death in two cases,[3,10] while another died immediately postoperatively.[26]

Subtotal Gastric Resection.—This procedure was done in four cases, by Custer[9] and Baker[1] because of an associated benign gastric ulcer; by Markovitz[20] for a perforating duodenal ulcer on the posterior wall; by Ohlmacher[23] because there was a huge dilatation of the duodenum, pylorus and stomach. Baker included a duodenojejunostomy, while Markovitz also resected the annular ring. All four patients responded without complication. Llorca[19] was completing a Peon-Bilroth I procedure when the annular pancreas with marked duodenal constriction was noted. No other procedure was done. Postoperatively, x-ray showed a persistent narrowing at the level of the second portion of the duodenum without a clinical manifestation.

Gastroduodenostomy.—Gastroduodenostomy was elected by Ravitch[25] in a newborn (third case) because of marked congenital deformity of the position and mesenteries of the abdominal viscera. The patient responded without complication.

Duodenojejunostomy. — Duodenojejunostomy was performed by Gross[13] and Ravitch[25**] in newborns, with excellent results. A 2½-pound premature infant with annular pancreas and duodenal stenosis died the fourth postoperative day following dividing the ring and duodenojejunostomy.[11]

Case Report

J.M.P., a twenty-six-year-old white man, single, was admitted to the Veterans Administration Hospital, Bay Pines, Florida, on September 22, 1950. He gave a history that he had received a medical survey and discharge in July, 1945, from the U. S. Navy, for "stomach trouble." Since discharge from service, the patient had

*First case in reference cited.

**Second case in reference cited.

not been on any medical therapy except a bland diet. The present illness began about five weeks prior to admission, when he noted loss of appetite, "gas pains," "bloatedness" and mild epigastric pain, all relieved by vomiting. On three occasions he vomited a small amount of blood, associated with transient melena. Past history was insignificant, and failed to reveal any childhood abdominal complaints or feeding problems.

Physical examination revealed an undernourished male, weighing 134 pounds. The examination was essentially negative. The gastric analysis showed a free HCl of 51° and a total acidity of 68.5°. X-ray examination revealed a narrowing of the post-bulbar segment of duodenum associated with spasm of the duodenal cap. At six hours there was gastric retention. Findings conform with a diagnosis of partial obstruction of the post-bulbar area of duodenum (Fig. 3). Gastroscopic examination was negative.

Course in the Hospital.—The patient was placed on conservative medical management. Overnight gastric drainage varied from 1,000 to 4,000 cc. The patient was transferred to the Surgical Service with the diagnosis of pyloric obstruction, probably due to cicatricial changes secondary to a duodenal ulcer.

The patient was operated upon on November 13, 1950. Exploration revealed the gall bladder and the porta hepatis obscured by a fold of peritoneum that extended from the liver edge to the lesser omentum and the hepatic flexure of the colon. This abnormal fold of peritoneum was incised along with the gastrocolic and gastrohepatic ligaments. The pylorus ended in the center of a mass of grossly recognizable pancreatic tissue that completely surrounded the duodenum. This pancreatic mass was continuous with or a part of the head of the pancreas. The neck, body and tail of the pancreas were normal in size and position. The pancreatic mass was dissected from the duodenum for a distance of 3 cm. distal to the pylorus. Further exposure of this area was not done as the location of the terminal biliary and pancreatic ducts was unknown. The duodenum exposed by dissection was small, being 1.3 cm. in external diameter and 0.7 cm. internal diameter (Fig. 2). Further exploration revealed this mass to encircle the first and second portions of the duodenum. The pancreatic mass was then recognized as an annular pancreas which was encircling and constricting the first and second portions of the duodenum and producing obstruction of the duodenum at the pylorus. A sub-total gastric resection was then accomplished by an anterior Polya-Hoffmeister procedure. The patient made an uneventful postoperative recovery and was discharged November 27, 1950.

Discussion

The case presented differed anatomically from annular pancreas as defined; the ring of pancreatic tissue encircled the first and second portions of the duodenum. In addition, the proximal portion of the duodenum exposed by dissection from the pancreas was hypoplastic. There were present abnormal peritoneal folds which obscured the hepatico-duodenal area. It was only after incising these folds that the duodenum with the encircling pancreatic tissue could be visualized. A review of cases presented in the literature reveals a frequent nota-

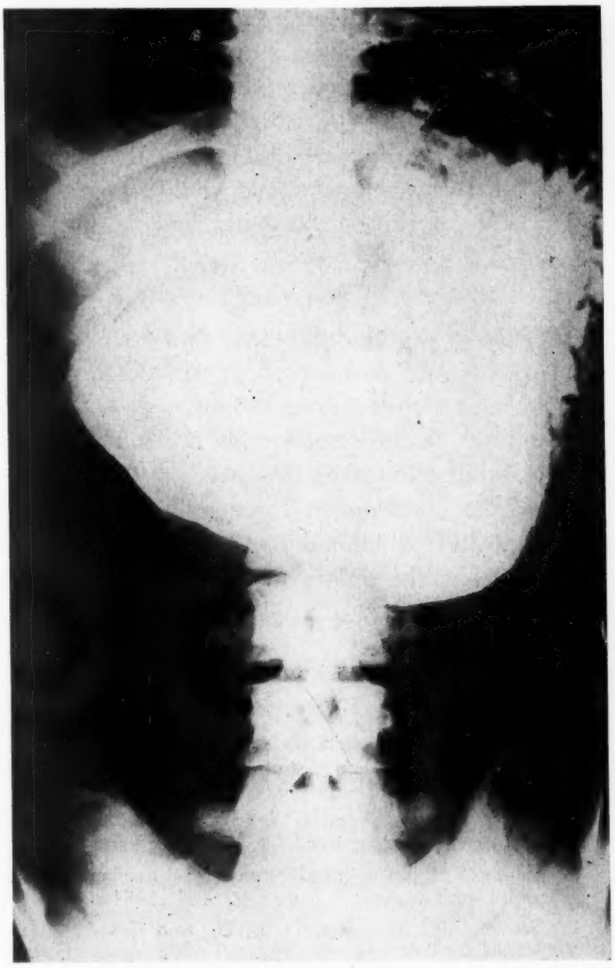

Fig. 3. X-ray showing the dilated stomach with retention.

tion of similar folds or adhesions. When fusion folds of peritoneum are encountered in this area, one should be cognizant that associated congenital anomalies of the gastrointestinal tract may be present. Six cases of annular pancreas[2,3,10,21,23,26] were not recognized at surgical exploration and were later demonstrated at autopsy.

The seven cases reported in the newborn demonstrated that annular pancreas must be considered in the causes of duodenal obstruction. It has been found singular or associated with other anomalies of the gastrointestinal tract.

Gross stated that duodenojejunostomy is the procedure of choice in the surgical treatment of duodenal obstruction caused by annular pancreas

as "it completely relieves the duodenal obstruction, does not interfere in any way with the gastric function and does not possess any of the hazards of cutting the pancreatic ring with its attendant danger of fistula, et cetera." This agrees with the conclusions stated by Howard, Lehman and Zeck. Gastroenterostomy alone and subtotal gastric resection have given good results. Following the use of these by-passing procedures, one may conclude that there was adequate drainage of the proximal loop, otherwise, complications would have resulted from acute or chronic duodenal stasis.

Summary

A case of annular pancreas that encircled the first and second portions of the duodenum, causing duodenal obstruction, and treated successfully by subtotal gastric resection, is presented. There was associated a marked hypoplasia of the first portion of the duodenum. Twenty-eight other cases of surgically treated annular pancreas have been reviewed and the treatment discussed.

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BRITISH MEDICAL PLAN SLIDING DOWNHILL

The once-famous and highly tooted British health plan is running into more trouble.

Newspapers reported recently that Churchill's government has introduced legislation to cut the cost of Britain's socialized medicine scheme by 21 million pounds or $58,800,000 a year.

The cut is being accomplished by sharply modifying the "free" provisions of the service. Under new provisions patients will have to pay.

The bill seeks to impose a charge of one pound ($2.80) for a course of dental treatment. A shilling (14 cents) charge will be imposed for drugs supplied through hospital outpatient departments.

Before going out of office last fall, the Labor party, which gave birth to the socialized medicine scheme, made the first big modification in the plan. The Laborites required patients to assume half the cost of false teeth and spectacles. Now patients also will have to pay half the cost of such items as wigs, hearing aids, surgical boots and elastic stockings if the bill goes through. And the Conservatives, with a majority of fourteen, are expected to push it through.

The New Versus the Old in the Treatment of Syphilis

By S. William Becker, M.S., M.D.
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IT HAS NOW been about eight years since Mahoney, Arnold and Harris treated the first four syphilitic patients with penicillin. Shortly thereafter a systematic study of the treatment of early syphilis by penicillin alone and in combination with other agents, such as fever, arsenicals and bismuth was inaugurated under the auspices of the Penicillin Panel of the Subcommittee of Venereal Diseases of the National Research Council. According to Chairman Moore, "This drug proved to be effective in syphilis in 1943, had been adopted by the U. S. Armed Forces by late 1944, and was in sufficient supply to become a factor in civilian life by 1946."

In 1944, it was my privilege to present at this meeting some of the early results at the Chicago Intensive Treatment Center under the auspices of Dr. Herman N. Bundesen, president of the Chicago Board of Health. I would like now to survey the worldwide over-all picture since the advent of penicillin, to present the individual and collective advantages of this and other antibiotic therapy, and to call attention to the disadvantages, if any.

First of all, it is appropriate to reiterate the statement of Thomas: ". . . while modern treatment of syphilis is becoming relatively simple, the disease itself continues to be extremely complex and treacherous. Many problems in syphilis remain unsolved, and we do not yet have an adequate understanding of the disease." In the old syphilology, not only was the disease itself complex and treacherous, but so was the treatment; hence, prolonged special training was necessary and constant vigil during treatment was imperative. We should not permit ourselves to be lulled into a false sense of security because of the relative simplicity and safety of treatment when we cannot even culture a virulent Treponema pallidum.

Administration of Penicillin

The early water-soluble crude penicillin had to be given every few hours around the clock, which necessitated hospitalization. The dose and dosage have been constantly increased so that there is a lag between administration of the drug and publication of treatment results. Cohn et al stated that it is best to administer a surplus amount of the drug. Purification of the product along with introduction of material which slowed absorption has decreased the necessary frequency of injection. The drug of choice at the moment is penicillin procaine in oil with aluminum monostearate (PAM), which is injected intramuscularly in doses up to 2.4 million units. At the Chicago Intensive Treatment Center, Rodriquez et al treated seventy-one patients with darkfield-positive early syphilis by a single injection of 2.4 million units of this material, 4 cc. being given into each buttock. All patients showed adequate blood levels of penicillin for four days. The percentage of satisfactory levels gradually decreased on subsequent days, but, even on the eleventh day, 3 per cent showed such levels. This decreasing level may be fortified according to the recommendation of Curtis et al of four additional injections of 600,000 units every four days. Penicillin is the first antisyphilitic drug that can be administered with impunity all the way from pediatric through geriatric practice. It is well tolerated by normal individuals, and has been given to nephritics by Merklen et al and Baliera et al with no untoward effects. In addition to the usual method of administration by intramuscular injection, it can also be given orally. Buerk and Tucker treated a hemophiliac by 500,000 units every two hours for a total of 48.0 million units in eight days. The Syphilis Study Section of the National Institute of Health stated that five times as much must be given by mouth as intramuscularly. Robinson and Robinson were disappointed by results of oral administration of 100,000 units of penicillin three times daily in buffered tablets to pregnant women with early syphilis. This dose is much smaller than proposed in the aforementioned recommendation.

Reactions to Penicillin

Reactions to penicillin, infrequent and, for the most part, inconsequential, have decreased in the last four years, largely as a result of purification and chemical alteration of the drug. Penicillin in oil and beeswax produced local urticarial reactions in almost everyone. With PAM, local reactions are negligible. Systemic urticarial eruptions have been experienced from most forms of penicillin,

Read at the sixty-eighth Annual Session of the Michigan State Medical Society, Grand Rapids, September 28, 1951.

less commonly from PAM, usually mild in degree, and ordinarily respond to antihistaminics. More stubborn outbreaks may be relieved by adrenaline or epinephrine, cortisone or ACTH. Other reactions appear in the form of erythematous, vesicular, desquamating eruption, serum-sickness-like eruption, eczema from epidermal allergy, and anaphylactic shock. The last named was recently reported by Everett following instillation of penicillin into the maxillary sinuses. These reactions are treated by the means just mentioned, along with appropriate local measures.

Herxheimer reactions are common in early syphilis. Moore, Jr., et al reported 39 per cent in patients with seronegative primary syphilis and 43 per cent in seropositive primary syphilis, and in 74 per cent of paretic patients. Putkonen and Rehtijärvi observed such a complication in fifteen of sixteen patients with primary syphilis and forty-nine of fifty-five with secondary syphilis. In congenital syphilis, all but one of the early cases showed intense febrile reaction. The temperature rises at the earliest in four hours after the first injection, reaches its maximum usually after six to ten hours and returns to normal within twenty-four hours. Such a reaction does not contraindicate further treatment by penicillin. Kadison et al recently reported on P-92 penicillin, a salt of 1,2, diphenyl-2methylaminoethanol, which produced as good therapeutic results but fewer reactions than did procaine penicillin. In penicillin intolerance, as shown by positive intradermal or patch test, Thomas suggested substitution of aureomycin, 4 gm. daily, for ten to fourteen days.

Resistance to Penicillin

In contrast to the well-known treponemal resistance to arsenical therapy in some patients, Guthe and Reynolds stated that there is no important evidence of treponemal resistance to penicillin. However, Boak and Carpenter noted a wide variation in sensitivity of five strains of Treponema pallidum in animals. Arnold found one batch of penicillin G to be twice as efficacious as the average in treatment of rabbit syphilis.

Prophylaxis

During the early arsenical era, prophylactic and abortive treatments of early syphilis were practiced. Later, because of relapses, the prevailing opinion was that, after exposure, therapy should not be administered until the appearance of definite signs of the disease. My own preference was for administration of an arsenical if the patient was seen within forty-eight hours after exposure. After a longer period, the individual was merely observed. Of course, all exposed persons, whether treated or not, must be watched for several months. Alexander and Schoch believe that exposed individuals should be treated. They reported results of administration to 148 persons who had been exposed to infectious individuals of 900,000 units of penicillin, 3.0 cc. of bismuth ethylcamphorate and 0.05 to 0.06 gm. oxophenarsine hydrochloride, all given at one visit. Only six of the 148 persons developed syphilis, in contrast to 100 of 161 individuals similarly exposed but not treated. Curtis et al stated: "Thus it is now possible to treat successfully primary and secondary syphilis patients as well as persons exposed to infectious syphilis with a single injection of 2.4 million units of penicillin procaine with aluminum monostearate at a single clinic or office visit."

Treatment of Early Syphilis

Thomas stated that the treatment of early syphilis should be completed in not less than four days and not more than eight days. Curtis et al recommended an initial dose of 2.4 million units, followed by four injections of 600,000 units every four days, for a total of thirteen days. They advised repetition of the course in six to eight weeks if results are unsatisfactory. Robinson and Robinson gave penicillin at weekly intervals for thirty-five weeks, and only 18.6 per cent of forty-three patients completed the course, even though treatment was free, surely a potent argument for shorter courses. For true relapse, Thomas suggests giving double the initial amount of penicillin.

Because of rapid and pronounced alteration in the titer of serologic tests during and following therapy by penicillin, quantitative techniques are more necessary than with older treatments, and are now considered indispensable.

As with the older methods of treatment, results from penicillin vary with the stage of the disease. Rodriquez et al obtained 100 per cent of apparent cures in sero-negative primary syphilis, 78.9 per cent in sero-positive primary and 53.4 per cent in secondary syphilis from a single dose of 2.4 million units. Moore called attention to the as yet irreversible 10 per cent of failures in early syphilis. He emphasized, as have Thomas and Landy, that fewer relapses and reinfections oc-

curred after prolonged arsenic and bismuth treatment than following penicillin, but believe that these advantages are more than counter-balanced by better control of the disease with rapid treatment by penicillin. Curtis et al reported 95 per cent success in early syphilis, a figure that was lowered to 90 per cent by relapses.

Treatment of Late Syphilis

Curtis et al recommend administration of 600,000 units daily or twice weekly for a total of 6.0 million units for treatment of late syphilis, including cutaneous, mucosal and visceral complications. In cutaneous and mucosal syphilis, penicillin does double duty in destroying both treponemes and secondary invaders.

Relative to cardiovascular syphilis, Barnett and Small concluded that antisyphilitic treatment probably improves the prognosis to some extent at any stage, but best results are obtained before the onset of symptoms, and penicillin is progressively less useful as the disease progresses. The dreaded therapeutic paradox in cardiovascular and hepatic involvement is not feared as much as previously. Webster et al stated that risk of therapeutic paradox has been overrated, and Moore stated that risk of therapeutic paradox in the course of penicillin treatment is minimal. Wheeler and Curtis stated: "There can be found in the literature no certain evidence of harmful results from penicillin treatment of cardiovascular syphilis." They reported that no convincing evidence of adverse effect in the form of the Herxheimer reaction or therapeutic paradox was observed in 21 previously untreated patients with cardiovascular syphilis to whom they gave penicillin. They concluded that preparation with iodides and bismuth is unnecessary. Lees, however, has seen therapeutic paradox in cardiovascular syphilis and suggests such preparation. Whorton and Denham reported sudden death on the fifth hospital day of a twenty-seven-year-old Negress with gummatous syphilitic aortitis. Penicillin was started in dose of 140,000 units every three hours. She died suddenly twenty-seven hours after treatment was started and she had received 1,400,000 units. Anatomic diagnoses were gummatous syphilitic aortitis with acute inflammation consistent with the Jarisch-Herxheimer reaction, pulmonary embolism and others. Preparation with bismuth and iodides might not have saved her life, but the necessary time would certainly not jeopardize the beneficial action of penicillin.

Curtis et al emphasized that compensation must be restored before penicillin therapy for cardiovascular syphilis. After this has been accomplished, 600,000 units are given twice weekly for five weeks, for a total of 6.0 million units. Webster et al gave 300,000 units daily for fourteen days and semiweekly for ten weeks, for a total of 10.2 million units. This is more in line with the belief of Bruetsch that, because of the extreme resistance of the syphilitic exudate in the wall of the aorta, 25.0 million units may be necessary.

Nicol and Terry treated a man with gummatous hepatitis and ascites. Malignancy had been ruled out by laparotomy. They gave 10,000 units of aqueous sodium penicillin intramuscularly every three hours for four days and 20,000 units every three hours for eighteen days. Diuresis commenced within forty-eight hours and reached a maximum of 4.450 liters on the ninth day. Edema and ascites disappeared by the fourteenth day. The patient still had slight ascites some months later. This dramatic result contrasts favorably to the slow response to prolonged iodide and bismuth therapy of the past. However, the residual ascites could conceivably have resulted from too rapid resolution of the gummatous process.

Treatment of Neurosyphilis

Woltman and Kierland recommended reduced doses of penicillin at the start of treatment in general paresis, optic atrophy and gumma of the central nervous system. They also advised a single course of fever treatment in case clinical improvement is not obtained. The penicillin course should be repeated if improvement is not seen in four to six months after treatment. Ingraham et al reported on 603 patients who received penicillin alone. They believe that the maximum sustained response is reached in from one to two years earlier when penicillin is used as compared with metal chemotherapy and fever.

Curtis et al reported on 430 patients. They concluded that penicillin alone is adequate for all types of neurosyphilis except possibly severe paresis and primary optic atrophy. Curtis et al recommended 600,000 units of PAM daily or twice weekly for a total of 6.0 to 12.0 million units. Malaria therapy may be advisable if results from penicillin are unsatisfactory. Bruetsch believes that

10.0 million units has the same effect as a course of malaria. Occasional persistence of a few treponemes in the brain suggests to him that perhaps 15.0 million units would be better in general paresis.

Smith and de Morais reported autopsy findings on four patients with general paresis who had died after receiving 2.4 to 4.8 million units of penicillin. Two had improved clinically and serologically. Their brains showed less inflammation and no treponemes were found, findings similar to those following malaria. The two unimproved patients had had juvenile paresis with rapid deterioration. Their brains showed no decrease in inflammation, but no treponemes were found. Gammon et al reported autopsy findings in seven patients with neurosyphilis. One died three weeks after treatment and showed the usual signs of the disease. Evidence obtained from the other six suggested that penicillin had cleared the infection.

Treatment During Pregnancy

Goodwin and Streeter stated that syphilitic women previously treated do not need to be retreated during pregnancy, provided that (1) at least 4.0 gm. arsphenamine and concomitant bismuth have been given, or (2) 2.4 million or more units of penicillin have been given, (3) she shows no sign of active syphilitic infection, (4) serologic test is negative or only weakly positive.

Ingraham reported 98 per cent success in treating pregnant women with 2.4 million units of soluble penicillin or 4.8 million units of delayed absorption penicillin. He stated that failures were due to starting treatment too late in pregnancy or to the mother's poor response to the drug. Shaffer and Courville reported on 631 pregnant syphilitic women. They attributed the 1.1 per cent of failures to relapse or reinfection late in pregnancy in women who failed to remain under observation. Curtis et al recommend 4.8 million units. In the first two trimesters, 600,000 units are given twice weekly or 1.2 million weekly. In the third trimester, 600,000 units are given daily. If labor is imminent, 2.4 million units are given at one time, to be repeated in one week if not yet delivered. For the pregnant woman with relapsing early syphilis, 900,000 units are given weekly for four weeks. Rosahn discussed the interesting fact that syphilis in the fetus is cured by fetal tissue concentrations lower than those in the mother.

Treatment of Congenital Syphilis

Nicol stated that penicillin is more effective in early congenital syphilis than in any other phase of the disease. Results are 100 per cent satisfactory provided the child is not marasmic, in which case general medical care is most important. Ingraham stated that the younger the person, the better the results from penicillin. In early prenatal syphilis (less than two years of age), Curtis et al recommended 10,000 units per pound of body weight daily for 10 days, or 15,000 units per pound twice weekly for four weeks or 40,000 units per pound weekly for four weeks. In late prenatal syphilis (over two years of age), 600,000 units are given daily or twice weekly for a total of 6.0 million units. For treatment of interstitial keratitis, Simpson et al instilled two drops of cortisone acetate in a 1:4 dilution with normal saline in each eye hourly from 6:00 a.m. to 10:00 p.m. for ten days. In addition, 600,000 units of PAM were given daily for twelve days. Of the nine patients treated, all but one had some beneficial results.

Geriatrics

For syphilitic patients over sixty years of age, Thewlis and Gale recommended a two weeks' preparation by potassium iodide and bismuth followed by procain penicillin, 300,000 to 500,000 units daily for a total of 5.0 to 8.0 million units in eight weeks. They also suggest supportive measures, such as a well-balanced diet, vitamins B, P, and C, and liver preparations.

Public Health Control

Guthe and Reynolds stated that in five years after World War II, the lowest level of incidence of syphilis in Scandinavian countries had been practically reached, a level that required twenty to twenty-five years after World War I. Thomas and Landry and Moore believe that increased relapse and reinfection rates following penicillin as contrasted to arsenic and bismuth are more than counterbalanced by the more rapid and better public health control of the disease by penicillin.

The efficient State Board of Health Control, carried out for many years in Minnesota by Dr. Harry Irvine, and in other states, has become nationwide. According to Sklar and Schuman, for the past twelve years, the Illinois State Department of Public Health has used special contact investigation procedure with private physi-

cians to obtain contact information from patients with early syphilis or gonorrhea. For each 100 patients interviewed, 41.6 contacts were found and examined. An average of 234 new patients, including eighty-five who had primary or secondary syphilis and 127 who had gonorrhea, were found each year. Premarital and prenatal blood tests, required by most states, and pre-employment blood tests in industry have been valuable in finding infected persons.

A recent report on the syphilis rate in Chicago selectees examined during 1950 showed a decline of 51 per cent for whites and 64 per cent for Negroes as contrasted to those examined in 1940-1941.

That syphilis is by no means controlled is shown by Aufranc's statement that in 1949:

1. It infected 150,000 persons, 80,000 of whom were undiscovered.
2. It sent 6,000 persons to mental institutions.
3. Its causative organism entered the blood stream of 14,000 innocent children.
4. It killed 13,000 people.
5. An estimated 3,000,000 persons in the United States would have had positive reactions if blood tests had been given to the entire population of the United States.

However, on the opposite side of the ledger is:

1. In 1949, infant mortality from syphilis was about one-fifth the rate for 1938.
2. Syphilis mortality has been reduced 48 per cent.
3. Admission to mental institutions because of syphilis have been reduced 34 per cent.
4. The reported attack rate of syphilis has decreased consistently for the past three and one-half years.

As occurs after all wars, early syphilis was declining in frequency before the advent of penicillin, the role of which in the further decline is stated by Moore as follows: "The effect of penicillin in possible further acceleration in incidence decline cannot yet be measured. At least another decade of experience is essential."

Guy reported that, in 1946, 721 cases of primary and secondary syphilis were reported to the Pittsburgh Syphilis Control Program, in 1948 there were 493 and, for the first five months of 1950, only 29. Epstein stated that, at the Marine Hospital in San Francisco, in the years 1946 and 1947, 200 to 250 patients were seen annually with primary and secondary syphilis. For the first quarter of 1950, there were only 20. Robinson and Robinson, on the other hand, believe that the decline has been merely normal for a post-war period, and that the present incidence in Baltimore is normal.

One of the burning problems of syphilology, as emphasized by Moore, in the public health effort against the disease, is elimination, if possible, of the so far irreducible 10 per cent of persons with early syphilis who are not cured by penicillin. In the United States the tendency is to re-treat with penicillin or aureomycin, while in other countries the use of arsenicals and bismuth is recommended. Marshall believes that arsenic and bismuth give the best results, and emphasizes the value of British antilewisite (BAL) in treatment of arsenical dermatitis. Differences of opinion may be attributable to the greater experience with antibiotic therapy in this country, coupled with the fact that better control over the populace in some foreign countries insures completion of longer metal therapy courses such as could not be attained in the United States.

No drug or combination of drugs has ever been found to be 100 per cent efficient. As regards penicillin, variation in human blood level, variation in potency in batches of penicillin and varying susceptibility to the drug on the part of spirochaetes have already been briefly mentioned. Combinations of antibiotics, as reported by Romansky and others, for treatment of infection produced by antibiotic-resistant organisms have not been tried extensively in syphilotherapy. Moore stated that no infectious disease in the history of medicine has been eradicated or even controlled by the sole process of treatment of infected persons. Immunologic control may sometime be possible if abundant virulent treponemal organisms can be cultured.

For co-operative private patients who have failed to respond to penicillin therapy for early syphilis, there seems to be no good reason why the prolonged arsenic-bismuth treatment, which was efficacious in the past, could not be administered with proper precautions.

Other Antibiotics

In addition to penicillin, other antibiotics have been found to be effective in the treatment of syphilis. O'Leary et al reported beneficial effect

of aureomycin in a patient with primary and one with secondary syphilis. Clinical and serologic results were satisfactory. One year later they reported satisfactory results in treatment of two patients with late cutaneous syphilis, and the following year Kierland and O'Leary reported good results in neurosyphilis. They believe that oral therapy may have some advantages over injections. Willcox believes that aureomycin may be valuable in prophylaxis against syphilis. Thomas recommended aureomycin for patients who are allergic to penicillin or fail to respond to it.

The next antibiotic that was used in syphilotherapy was chloramphenicol (chloromycetin), as reported by Smadel et al primarily on treatment of gonorrhea. However, they gave the drug to two patients with primary syphilis. There was a definite effect, but the action was slower than that of penicillin. Hendricks et al treated four patients with early syphilis by means of terramycin. There was a definite clinical result, but the patients experienced nausea, vomiting and diarrhea. Robinson and Robinson treated patients with early syphilis by penicillin, chloramphenicol, aureomycin, both intravenously and orally, and terramycin. They maintain that patients taking a drug by mouth must be hospitalized to make sure they receive it regularly. Chloramphenicol, aureomycin and terramycin were effective, but should be studied further.

Summary

Penicillin is a safe, inexpensive, rapid and efficacious treatment for early syphilis.

Superior results of arsenic-bismuth combination are counterbalanced by the danger to life and failure of many patients to complete the long course. However, BAL has decreased the danger of arsenical poisoning.

Quick cure by penicillin clears the path for reinfection.

Penicillin treatment for late syphilis is efficacious. Damaged parenchyma cannot be replaced.

High doses of penicillin are necessary for treatment of general paresis and cardiovascular syphilis.

Short preparation by bismuth and iodides may be of assistance in visceral syphilis, neurosyphilis and even late or recurrent secondary syphilis. Reduced initial doses of penicillin may accomplish the same result.

In addition to rapid public health treatment of infectious syphilis by penicillin, better search for contacts, pre-employment, premarital and prenatal blood tests have been of assistance in the control of early and prenatal syphilis.

Prophylactic treatment of exposed persons by a single large dose of penicillin (1.2 to 2.4 million units) is recommended.

Penicillin seems to have accelerated the postwar decrease in the incidence of early syphilis.

Penicillin-arsenic-bismuth treatment for cooperative private patients might help to reduce the 10 per cent failures following rapid treatment by penicillin alone.

Aureomycin, chloramphenicol and terramycin are efficacious in the therapy of syphilis, but further study is necessary to determine their value.

MSMS

INCOME TAX INEQUALITIES

Here are some examples of the absurd inequities that have evolved in our tax structure. Today a husband, wife and two dependents pay $72 on a gross income of $3,000. Similarly circumstanced, a worker with the ability and industry to earn $6,000, twice the income, pays a tax of $666, nine and one-quarter times as much! And any wretch who had the temerity to earn three times that amount, or $9,000, pays eighteen times as much income tax, or $1,306!—B. E. Hutchinson.

TAX REVOLUTION

The Constitution provides, Article I, Section 8: The Congress shall have power to lay and collect taxes, duties, imposts, and excises, to pay the debts and provide for the common defense and general welfare of the United States; but all duties, imposts and excises shall be uniform throughout the United States.

The ratification in 1913 of the *Sixteenth Amendment* providing that "the Congress shall have power to lay and collect taxes on incomes, from whatever source derived, without apportionment among the several states, and without regard to any census or enumeration" changed fundamentally the basis and character of our government. By permitting flagrantly discriminatory taxation as between citizens it undercut the sanctity of the right of all citizens to own private property. Men now enjoy the fruits of their own labor only to the extent decreed by Congress. There is no limitation in law or in equity.

Representations were made at the time that the discrimination would be nominal. The mere mention that it might amount to as much as five per cent was considered shocking! *Only a few then were vaguely apprehensive of what has been amply demonstrated since, that the delegation to our federal government of the power so to discriminate in imposing the tax burden was an open invitation to demogoguery of which full advantage would be taken.*—B. E. Hutchinson, Annual Meeting, Chamber of Commerce of U. S. A., April 29, 1952.

Constitutional Anomalies in Recalcitrant Trichophyton Purpureum Infections

By Stephen Rothman, M.D.
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RECALCITRANT INFECTIONS of the skin and nails with the filamentous fungus trichophyton purpureum are well known to all dermatologists. Particularly common is the intractable infection of palms, soles, fingernails and toenails. This infection has a few peculiarities which are entirely unexplained. The first peculiarity is that although the localization on palms and fingernails gives plenty of opportunity for transfer from one person to the other, such transfer within the family, in the plant, in school, et cetera, has never been recorded. This indicates that possibly some individual disposition is required for the take of this infection. The second peculiarity is that the infection often remains remarkably localized, for instance, to some of the nail plates, whereas other nail plates remain unaffected even after the onychomycosis has persisted for years or decades. Even more conspicuous is the unilateral involvement of one palm for years and decades without involvement of the other palm (Table I). In the material here presented we had thirteen cases with palmar involvement, out of which six were unilateral. In five patients the right palm was involved and in only one was the left palm involved. We inquired if this man is left-handed but he is not. Still, the great prevalence of right palm involvement suggests that, in general, the greater use of right hand involving more intense sweat secretion may be one factor. Kuno pointed out that on palms and soles sweat is most abundant in those areas where mechanical stimulation, particularly pressure, is habitual.

Also the affinity of t. purpureum to palmar skin as contrasted with t. gypseum is remarkable. All palmar mycoses I saw in thirteen years at the University of Chicago Clinics were caused by t. purpureum and none of them by t. gypseum.

In any case, it is clear that, in addition to individual susceptibility factors, also regional or local susceptibility factors must be in operation.

TABLE I. UNILATERAL PALM INVOLVEMENT IN SIX OUT OF THIRTEEN CASES

Name	Sex	Age	Site	Handed
E.L.	M	24	Right palm	Right
H.O.	M	44	Left palm	Right
V.P.	F	23	Right palm	Right
W.C.	M	38	Right palm	Right
I.M.	F	61	Right palm	Right
E.S.	F	29	Right palm	Right

Individual and regional susceptibility factors have been traced in many fungus diseases, the best known example being the intertriginous moniliasis or candida albicans infections of diabetics. However, the t. purpureum infections have one more peculiarity which is unique. These fungi can be inhibited in the test tube by fungistatic agents with the same ease or easier than other filamentous fungi, but *in vivo* they are much more resistant to the same fungistatic agent than the others. Clinically entirely analogous t. gypseum infections of the soles, for instance, respond very satisfactorily to treatment with tincture of iodine, sulfur-salicylic ointments, fatty acid preparations, or to more modern compounds such as the salicylanilid-undecylenic acid combination, asterol, et cetera. With most of these preparations and in most cases clinical cure of the soles can be achieved within two weeks so that the patient is completely free of signs and symptoms if the causative agent is t. gypseum. Nothing like that can be achieved in cases of t. purpureum. The best illustration of how intractable these infections are is that the average duration in our material composing twenty cases has been around five years. The majority of our patients consulted a great number of expert dermatologists and tried practically all available fungistatic agents before they came to our clinic, usually with a most virulent infection. Nevertheless, fungi could be demonstrated microscopically and culturally in 100 per cent of the horny fragments which were taken from skin and nails in these patients.

This contradictory behavior of t. purpureum *in vitro* and *in vivo* remains to be elucidated.

I became interested in this problem five years ago when seeing a patient with unusually widespread t. purpureum infection of the neck, trunk, and extremities of two years' duration. The clinical picture was unusual. In addition to tinea circinata lesions, there were papules and eczematiform

From the Section of Dermatology, Department of Medicine, University of Chicago.

Read at the eighty-sixth Annual Session of the Michigan State Medical Society, Grand Rapids, September 26, 1951.

TABLE II. GLUCOSE TOLERANCE TEST IN TWENTY PATIENTS WITH RECALCITRANT T. PURPUREUM INFECTION

Name	Sex	Age	Glucose Tolerance		BMR	Remarks
			On Oral Testing	On I.V. Testing		
H.S.	M	37	increased	increased	−11	
O.A.	M	22	borderline	normal	−19	
E.F.	F	45	increased	−	+6	
J.W.	M	40	normal	−	+12	42 mg. % 2 hour value in oral tests
E.R.	M	24	increased	normal	−9	
O.B.	M	44	normal	−	−	
M.F.	F	41	increased	lower border of normal	−4	
C.A.	M	41	increased	lower border or normal	+9	
W.C.	M	38	normal	−	−8	
C.G.	F	44	borderline	−	+13	
S.W.	M	28	borderline	−	−1	
S.B.	M	48	normal	−	−17	
V.P.	F	23	increased	−	−	
E.L.	M	24	normal	−	+4	
M.W.	M	48	slightly elevated	−	−4	
S.K.	M	28	increased	increased	0	
E.B.	M	24	borderline	−	−	
L.W.	F	19	normal	−	−7	
E.S.	F	29	increased	−	−18	
E.H.	M	55	borderline	−	−	

"Increased" oral tolerance = peak value 105 mg. % or less.
"Borderline" oral tolerance = peak value 122 mg. % or less.

crusted lesions, as described in the older literature under the name "eczema trichophyticum"; such lesions are known to occur when the patient has a high degree of trichophyton sensitivity. Furthermore, there were lichenified lesions simulating dry neurodermatitis but these lesions too, like all the others, yielded abundant amounts of fungi.

This patient was obese, pale, pasty, slow in all his reactions and sensitive to cold. All this made him suspicious of being hypothyroid. He was subjected to a detailed work-up. His basal metabolism rate proved to be normal (0) and thus the suspicion of hypothyroidism had to be abandoned. However, his oral glucose tolerance test yielded a conspicuously flat curve. To exclude the possibility that this was due to delayed gastric absorption, an intravenous tolerance test was carried out. Except the fasting value, all values were below the normal range of Lozner, Winkler, Taylor and Peters. The patient responded poorly to local antifungal treatment. On suggestion of Dr. H. Rickets, director of our Metabolism Clinic, we put the patient on a ketogenic diet (1,500 cal. with fatty acid to carbohydrate ratio of 3.5:1). The clinical impression was that the patient did much better while on this diet and continued his local treatment, but his lesions did not heal completely and fungi still could be cultured from the lesions when the patient refused to continue his diet.

This case was so intriguing that I decided to carry out the glucose tolerance test in further cases of t. purpureum infections. Up to date the oral test was carried out in twenty patients, the intravenous test in six of them (Table II). Eight out of twenty cases showed unusually increased glucose tolerance on oral testing, four were at the lower border of normal, seven were normal, and one was slightly elevated. In intravenous testing only one additional patient showed throughout abnormally low values like our first patient. In the remaining five cases the values were either on the lower border of the normal range or entirely within the normal range.

Still, the fact remained that with oral testing a little less than half of the patients showed a highly unusual type of curve.

Unfortunately in the literature of glucose tolerance tests only the upper limits of normal values are well standardized because of the great significance of these values in the discovery of incipient diabetes. Nobody has ever dealt quantitatively with abnormally flat curves; the lower limits of normal values in the glucose tolerance test are not established. From a remark of Watson, it may be concluded that one-half hour values as low as 115 mg. per cent are exceptional. I could not find any lower one-half hour values than 112 mg. per cent in the literature of glucose tolerance tests in normals. Lennox tested thirty-one normals and found one case with a peak value of only 112 mg. per cent. His next lowest peak value was 126 mg. per cent. Qualitatively it is known that flat curves occur in hypopituitarism, adrenal insufficiency and in myxedema. Such endocrine disorders have not been present in our patients. They did not have clinical signs of any of these diseases and the basal metabolism rate of all of them was within normal limits. For all practical purposes, these persons have been perfectly healthy individuals. Thus one can only assume that their increased glucose tolerance on oral testing is a constitutional peculiarity, the nature of which is not understood.

Still, the question arises as to whether this peculiarity can be linked in any way to the susceptibility towards t. purpureum and to the intractability of the infection.

Little is known about the carbohydrate metabolism of the skin proper, but it is well established that alimentary hyperglycemia causes a considerable increase in the glucose content of the skin. So-called skin glucose tolerance tests were performed by serial biopsies of normal skin before and

after ingestion of 100 gm. glucose. The one-half hour glucose values in the skin were about 100 per cent higher than the fasting values, and they remained in this high range much longer than the blood sugar values, namely, three hours and longer. It appears that if a person ingests considerable amounts of carbohydrates with three or more meals per day his skin sugar will be almost continuously considerably higher than the fasting value.

The skin sugar level is certainly influenced by the blood sugar level, and it may be assumed that a person whose blood sugar does not rise or rises only a little after ingestion of carbohydrates will have a lower average sugar content in his skin than persons with a normal degree of alimentary hyperglycemia.

Dermatophytae thrive well on media which contains both glucose and nitrogenous material. If glucose is present, they preferentially metabolize glucose, as indicated by the fact that in the presence of glucose their respiratory quotient is 1. However, they can adapt themselves to a medium free of glucose. In such glucose-free media the respiratory quotient was found to be 0.87, corresponding with a respiratory quotient which is obtained when not glucose but other substances are burned (F. M. Melton).

The first assumption in our working hypothesis is that some individuals for constitutional reasons have so little glucose on their skin surface and in their horny layer that if a fungus invades such a medium it has to adapt itself in a similar way as it does in an artificial glucose-free medium. Our second assumption is that all available fungistatic agents inhibit the thriving of fungi primarily by interfering with their carbohydrate utilization. Tentative evidence for this second assumption was presented by Grunberg et al. If this second assumption is correct we must be able to show that a strain which has grown for a while on a pure peptone medium withstands the inhibiting effect of fungistatic agents better than strains which have grown on media containing glucose. This is actually the case. Table III shows an experiment in which a fungistatic agent, pelargonic acid, a straight-chain saturated fatty acid containing nine carbon atoms, was added in graded concentration to the media. In one series a pure peptone medium was inoculated with a strain which was carried for six months on peptone, and in the other series a glucose-peptone medium was inoculated with a strain which was carried for five months on a glucose-peptone medium. In this experiment the peptone-bred strains proved to be four times more resistant than the strain bred on glucose-peptone. A second experiment had a similar result.

TABLE III. FUNGISTATIC THRESHOLD CONCENTRATION FOR PEPTONE-BRED AND GLUCOSE-BRED STRAINS

Pelargonic Acid Concentration	1	2
0	++	++
1:200,000	++	−
1:100,000	+	−
1:50,000	−	−
1:25,000	−	−
1:12,500	−	−

1=peptone-bred strain inoculated on peptone.
2=glucose-peptone-bred strain inoculated on glucose-peptone

Many more experiments are being planned and have to be performed before the working hypothesis here presented can be regarded as valid. In the meanwhile we may ask whether all these findings and speculations may have any practical application towards a more effective therapy. I already mentioned the attempt to influence the increased glucose tolerance by ketogenic diet. In the first case it seemed to help but the treatment was too short. In the second case a patient, a forty-one-year-old housewife, was kept on a ketogenic diet for six weeks (40 gm. carbohydrates, 160 gm. fat, 2,000 cal.). This patient did not improve on this diet, and she remained mycologically positive. Again on Dr. Ricketts' advice this patient was given, in addition to the local anti-fungal treatment, thyroid tablets, 1 gr. three times daily in an attempt to raise her alimentary glycemia. Clinically, she started to improve right after this treatment, and in one month her palms completely cleared up. Not trusting the situation, I have continued this treatment up to date, for a total of nine months without any side effect. However, her glucose tolerance test did not change much, and worse than that, her nails did not clear up. Her palms are perfectly clear.

In the case of a forty-six-year-old man with a bad t. purpureum infection of the soles and feet the thyroid medication also seemed to help considerably. After six weeks this patient disappeared from further observation.

In a few other cases thyroid therapy had to be discontinued because of poor tolerance, and thus so far I have only one case in which this therapy

(Continued on Page 856)

Hypospadias

By A. I. Dodson, M.D.,
and
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HYPOSPADIAS is among the most frequent congenital deformities and is extremely disturbing both to parents and child. In recent years, pediatricians and obstetricians, realizing the advancements that have been made in correcting these conditions, are prompt to apprise the parents of the deformity. Consequently, we are frequently visited by anxious parents with small children, seeking advice about the nature of the condition and the possibilities of correction. Fortunately, in most instances a normal or almost normal condition can be expected following properly applied plastic procedures.

Hypospadias occurs once in about every 300 births and may vary from the simplest type of deformity, in which the meatus is situated just in front of the frenum with practically no downward curvature of the penis, to a condition so severe that it may be difficult to determine immediately the sex of the child. It is natural, therefore, that the parents are greatly concerned and that if the condition is not corrected, the child in later life may have difficulties in adjusting himself to society.

Before beginning the treatment, it is well to discuss with the parents the operative procedures involved and the results expected. They should be advised that the excision of scar tissue will liberate the hypospadiac opening and cause it to be situated further posteriorly. They should be acquainted also with the fact that several operations may be necessary before a complete cure is obtained. In this way much dissatisfaction may be avoided. When the downward deformity has been completely corrected, the child will develop normally and plastic procedure for the formation of an anterior urethra can be taken care of at a later date. When possible, all plastic procedures should be completed by the time the child is six years old or before he starts to school. Children are much more apt to behave normally and will not so frequently develop personality problems when they are not handicapped by deformities or disturbances that make them in any way different from other children.

There is some difference of opinion as to the optimum age for undertaking plastic correction. It seems preferable to begin the operative procedures early. This, of course, depends somewhat upon the growth and the health of the child, but in most instances the first operation should be done by the time the child is two years of age. In most cases there is a downward curvature of the penis, which usually varies with the extent of the hypospadias. The type in which the hypospadiac opening is situated at or behind the penoscrotal junction is accompanied by a much more severe deformity than one in which the opening is situated further forward.

The first step in treatment consists of dissecting out the bands of scar tissue which bind the penis downward. The operation is begun by making a transverse incision in the skin on the under surface of the penis a short distance beyond the hypospadiac opening. Buck's fascia is divided and all constricting bands of scar tissue are dissected away from beneath the hypospadiac opening to the base of the glans penis. These bands of fibrous tissue are situated mostly between and along the ventrolateral margins of the corpora cavernosa. The dissection should extend back beneath the terminal portion of the urethra for a short distance. In advanced degrees of hypospadias, it is better to make two transverse incisions, one just anterior to the hypospadiac opening and the other posterior to the base of the glans penis. When the dissection has been completed, all bleeding is carefully controlled and the fascia and the skin are closed in the opposite direction of the incision. If the skin appears to constrict the penis, short longitudinal incisions may be made on the dorsal surface and sutured in the opposite direction, thereby relaxing the skin. This aids in healing and has a tendency to shift skin from the dorsal to the ventral surface of the penis for future need in constructing the urethra.

Occasionally, the fibrosis seems to involve the adjacent skin to the extent that when the penis has been straightened there is not sufficient skin to cover the defect. In such cases, the prepuce may be transferred to the ventral surface of the penis as has been suggested by Edmunds, Blair and Nesbit. In the operation described by Nesbit, the prepuce is retracted and an incision is made

From the Urological Service of St. Elizabeth's Hospital, Richmond, Virginia. Presented at the eighty-sixth Annual Session of the Michigan State Medical Society at Grand Rapids, September 26, 1951.

around the penis about one-half inch posterior to the corona, the skin is then retracted backward and dissected from the shaft sufficiently to expose and remove all constricting bands from the ventral surface. An incision is made through the redundant prepuce near its base and the glans penis is pulled through this incision. In this way the redundant portion of the prepuce is transferred to the ventral surface of the penis. The margins of the incision through which the glans has been pulled are sutured to the wound posterior to the corona and the free margin of the prepuce is sutured to the margin of the skin incision below. In this way an abundance of skin is available for the formation of the urethra at a later operation. If possible, it is better to leave the prepuce undisturbed. It is frequently useful in constructing a portion or all of the urethra.

When the straightening operation has been completed, it is well to suture the glans penis to the skin of the lower abdomen so that the penis will be held straight while healing is in progress. A small catheter may then be inserted into the hypospadiac opening and fixed in place to drain the bladder for the first few days. A light pressure bandage completes the procedure.

Before the new urethra is constructed, the urine must be diverted, preferably by a perineal urethrostomy. In a child, the urethra is situated very close to the skin, and this is an easy procedure. A simple method is to insert a small catheter into the bladder through the hypospadiac opening. The catheter is coiled into the bladder until only 4 to 6 inches protrude. A small stiff probe is then inserted into the lumen of the catheter and the point made to press against the perineum; a short incision is made over this area, exposing the catheter. The catheter is grasped, the probe removed, and the distal end of the catheter withdrawn. The catheter is adjusted so that only a couple of inches remain in the bladder. A suture of heavy silk or silkworm gut, placed around the urethra just anterior to the urethrostomy wound and tied just tightly enough to occlude but not injure the urethra, will prevent urine from escaping by the catheter into the newly constructed anterior urethra.

In cases of severe deformity where several operative procedures are contemplated, it has been found advantageous to form a semi-permanent perineal opening. Here an incision about one-half inch long is made into the urethra and the mucous membrane of the urethra is sutured to the margins of the skin. The child then voids through the perineum until the operations have been completed. After this an incision is made to liberate the urethral mucous membrane and the perineal urethra is reconstructed. This operation has some advantages in that it obviates the necessity of wearing a catheter and sometimes of making repeated urethrostomy openings.

In cases of perineal hypospadias, the hypospadiac opening serves for drainage while the penile portion of the urethra is constructed. When the anterior urethra is completely healed, the perineal defect may be closed over a small catheter which is left in the bladder for drainage. Considerable tissue can be closed over the repair and fistulas are not troublesome in this area.

Almost everyone interested in plastic surgery has devised an operation, or a modification of one, for the correction of hypospadias. The appendix, the ureter, the saphenous vein, and tubes constructed from the mucous membrane of the bladder and split grafts from the skin have been utilized. As a rule, these free transplants are not as satisfactory as pedicle grafts. Transplanted tissue often sloughs or is absorbed, and at best a constricted tube results which must be repeatedly dilated to maintain an open channel. The least complicated operations are more apt to be successful. The principles involved in pedicle grafts are embodied in the operation described by Thiersch, Bucknall and Ombredanne. These operations, modified according to the problem at hand, are likely to be successful. No one method can be applied in all cases. The technique of these operations is familiar or can be obtained from the original sources. The newest addition to the list of operation procedures for correction of hypospadias is that of Dennis Brown. This technique seems good, but further cases must be accumulated before it can be properly evaluated.

The senior author prefers the Thiersch method of constructing the urethra whenever it can be applied. In this operation the urethra is constructed from the skin of the penis with the roof of the urethra left attached along the entire surface. By this method there is no doubt that the canal will develop with the development of the penis. A broad base assures adequate blood supply and the line of sutures for constructing the urethra and the sutures for closing the skin flap over the urethra are not opposite each other, and post-

operative fistulas are relatively infrequent. If there is not enough skin left after constructing the urethra to close the defect without tension on the sutures, the prepuce may be used to cover the defect. If the prepuce has been removed, the operation may be completed by using Cecil's modification of the Bucknall operation or by using a skin flap from the scrotum as suggested by Blair.

The Bucknall operation is usually a successful method of constructing the urethra. There is the assurance of an adequate blood supply, and postoperative fistulas are rare. It has the disadvantage, however, that a portion of the urethra is formed from scrotal skin. This creates a possible hazard from the growth of hairs into the urethra. Cases have been reported in which calculi formed on these hairs and troublesome infection and fistulas formed years following the correction of the hypospadias. This disadvantage may be overcome by Cecil's modification in which the urethra is formed from the skin of the penis by dissecting up longitudinal flaps to form a tube just as is done in the method of Thiersch. A longitudinal incision is then made in the scrotum and the newly formed urethra is buried in the scrotum by suturing the margins of the scrotal incision to the margins of the wound on the ventral surface of the penis. After several weeks the penis is dissected from the scrotum and the operation completed as in the original Bucknall operation. In both the Thiersch and the Bucknall operations the newly formed urethra terminates in the region of the frenum. This gives satisfactory functional results, but falls somewhat short of the perfection desired by most patients and particularly by the parents of young children.

The most satisfactory method of carrying the urethra to the end of the penis is the use of a pedicle graft as recommended by D. M. Davis. This tube is constructed from the dorsal skin of the penis. Incisions begin at the margin of the prepuce and may extend backward almost to the base of the penis, depending upon the length of the tube graft needed. They should be from one-half to three quarters of an inch apart, depending upon the age of the child. The intervening skin is dissected up from both margins and a tube is formed over a catheter by suturing the margins of the graft together. The sutures should be of very fine plain catgut and should be placed in such a manner as to turn the margins of the skin inward. A transverse incision is then made at the margin of the prepuce and the tube separated from the dorsal surface of the penis. Care should be taken to preserve the blood supply of this tube. A liberal stab wound is made through the glans penis. The incision should be made about at the normal location for the urethral meatus. Frequently, a dimple in the anterior portion of the glans indicates the proper area. The stab wound is carried back through the glans, emerging well behind the frenal area. In patients with a hypospadiac opening situated midway the penis or a little further forward, the tube graft may be made sufficiently long to be anastomosed directly with the hypospadiac urethra. When the tube is intended to extend the urethra from the distal end of a Thiersch or Bucknall graft it need only extend back behind the frenum. The end of this tube is then anastomosed with the newly formed urethra or with the hypospadiac urethra.

In most cases better results will be obtained by suturing the tube in place and permitting complete healing to occur before the anastomosis is done. In older children and in adults, it is frequently possible to combine the straightening operation with the formation of the channel through the glans penis by this tube graft. This not only simplifies the final construction of the urethra but also aids in holding the penis straight while healing.

The Ombredanne operation is the most unsatisfactory of all pedicle graft methods of constructing the urethra. It has two advantages which have made it fairly popular. In the first place, the execution of the operation is not very difficult, fistulas are rare, and a completed urethra can usually be expected. In the second place, diversion of the urine is not necessary. The principal disadvantages of the Ombredanne operation are: First, it gives an extremely poor cosmetic result; there is very little similarity between the average Ombredanne pouch and a normal urethra. Second, if the meatus is situated near the penoscrotal area, a portion of the urethra must be formed by scrotal skin; consequently, there are the disadvantages of hairs growing into the urethra. In mild degrees of hypospadias with the meatus situated at the frenal area with very little penile deformity, the Ombredanne operation can be applied with very good results. Here, the entire urethral portion is formed of skin from the ventral surface of the penis and the flap does not have to be so wide. Consequently, a reasonably normal

urethra can be obtained and the meatus can be advanced almost to the tip of the penis. Diversion of the urine with a small catheter for two or three days is of value. If the frenal hypospadias is accompanied by pronounced deformity of the penis, the operation is done in two stages, using a pedicle tube graft to construct the urethra.

In the construction of the urethra, many types of suture material have been recommended, including silver wire, stainless steel, horse hair, silk and catgut. In actual experience, the material used is of little consequence; the results are largely dependent upon the care with which the sutures are placed. On the whole, better results are obtained with the use of catgut. For the construction of the urethra, very fine plain catgut is quite satisfactory, preferably 000 in size. Sutures must be placed so that the skin edges will be turned into the urethra. A more even tension can usually be secured by using interrupted sutures. The slightest defect in the suture line may be the cause of a fistula. Fine chromic catgut or silk are satisfactory for the superficial sutures. In small children, chromic catgut is more satisfactory because of the discomfort caused by the removal of nonabsorbable sutures.

No plastic procedure requires more careful postoperative attention than the operation for hypospadias. When the operation is completed, the catheter should be carefully inspected to determine that it is in the proper position for free drainage. The dressing should be applied with moderate pressure. A soft sea-sponge covered with a few layers of gauze and held in place by strips of adhesive provides even, elastic pressure. A fairly thick coating of sulfonamide ointment applied over the wound is helpful. This prevents the gauze from sticking. When the child is returned to his bed, he should be watched closely for several days. The slightest evidence of poor bladder drainage as indicated by discomfort or leakage around the catheter requires immediate attention. Contamination of the wound with urine discharging through the newly formed channel is one of the most frequent causes of wound dissolution. At the end of a week the catheter should be changed, as deposits of salts from the urine gradually occlude the catheter. Drainage should be continued until the wound is entirely healed or until it is evident that the operation is unsuccessful. When the patient has passed puberty, small doses of stilbestrol are helpful. The first dressing is changed about forty-eight hours following operation, provided there is no indication, such as unusual pain or excessive bleeding, to require that it be changed sooner. When there has been subcutaneous bleeding, the blood can be evacuated and edematous areas can be punctured with a pointed knife, thereby reducing tension. Subsequent dressings are applied without pressure. A minimum of two weeks is required for healing. In a reasonable number of these patients slight dissolution of the wound occurs, usually consisting of a minute fistula, and occasionally fairly large portions of the urethral wall will break down. When such evidence of failure is noted, it is useless to attempt to correct the condition immediately. It is best to discontinue treatment and permit the patient to return home, to be readmitted for further surgical correction after a period of six months.

When a large area has broken down, the most satisfactory method of repair is to liberate flap and reconstruct this portion of the urethra. The denuded area is then buried in the scrotum in the same manner that the urethra is buried in Cecil's modification of the Bucknall operation. After a period of three or four months the scrotum can be dissected away and the skin closed. When there are small fistulas, the method suggested by D. M. Davis is satisfactory. An incision is made around the margin of the fistulous opening, and the fistulous tract is dissected free from the overlying skin. A straight needle threaded with silk is passed through the urethral meatus, eye first, and made to emerge through the fistulous opening. One end of the thread is clamped and left emerging through the urethral meatus; with the needle a purse string suture is taken around the margins of the fistulous opening. The needle is then inserted, eye first, and carried out through the urethral meatus; both ends of the thread are then pulled upon, thereby inverting the fistulous tract. The subcutaneous tissues and skin are closed, and a very small urethral catheter is passed through the urethra and fixed in place for drainage. The sutures which emerge from the urethra may be tied around the catheter under moderate tension, or they may be sutured to the glans penis. After a few days the sutures will cut out, and by that time healing is usually complete.

A summary of cases operated upon by the senior author during the years 1935 through 1949 is as follows:

Total number of patients....	75
Total number of operations	182
Total hospital days.....	1625

Type of procedure:

Freeing and lengthening.....	63
Thiersch	24
Dorsal tube (Davis).....	34
Scrotal flap.....	4
Other flaps.....	15
Ombredanne	6
Perineal urethrostomy.....	56
Fistula repair.....	34

Degree of hypospadias:

Glandular	5
At or near coronal sulcus....	36
Mid-penile shaft.....	8
Just beyond penoscrotal junction	4
Penoscrotal	16
Perineal	5
Unable to determine from record	1

Complications:

Fistula—immediately postoperative:	
Penile	7 single
	2 multiple (2-3)
—after healing	
Penile	24 single
	4 multiple (3-3-2-2-)
Perineal	4
Wound breakdown	3
Stricture	2
Pneumonia	1
Epididymitis	1
Pyelonephritis	1

Lower urinary tract sepsis occurred so frequently as to be considered almost a concomitant of the operative procedure. In recent years, with the use of sulfa and the antibiotics the incidence and severity of infection have been markedly reduced.

Other anomalies noted in this group were:

Pseudohermaphrodism	2
Gynecomastia	2
Hypolydigism	1
Bilateral undescended testis.....	3
Single undescended testis.....	2
Speech impediment.....	1
Crossed eyes.....	1
Urethra imperforate at birth.....	1
Nevus of forehead.....	1

In conclusion, it is well to mention that most operations for the correction of hypospadias fail because the principles underlying plastic surgery are neglected. Adequate blood supply is absolutely necessary for good results. A broad pedicle should be left for the nourishment of the flaps which should be dissected just far enough to be approximated accurately without tension. In outlining flaps and grafts, it is important to remember that the skin of the penis or scrotum shrinks considerably when it is dissected free. Efforts to construct and cover the urethra with inadequate skin flaps result in excessive tension on the sutures. This interferes with the blood supply along the suture line and retards healing. Absolute hemostasis is also of greatest importance; even the most minute bleeding point should be controlled. Blood clots and infection, usually resulting from urine leakage and soiling, are the most frequent causes of wound breakdown.

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CONSTITUTIONAL ANOMALIES IN RECALCITRANT TRICHOPHYTON PURPUREUM INFECTIONS

(Continued from Page 851)

could be given a fair trial. Although one certainly cannot draw conclusions from our findings up to date, the impression in three cases has been that thyroid administration may favorably influence the course of recalcitrant t. purpureum infections.

Summary

1. In eight out of twenty cases of intractable t. purpureum infections an unusually increased glucose tolerance was found on oral testing. The values on intravenous testing were abnormally low only in two cases.

2. A working hypothesis is presented, postulating that if the glucose content of the skin surface and horny layer is low, the fungi adapt themselves to metabolizing substances other than glucose and thereby become more resistant to fungistatic agents which primarily inhibit carbohydrate utilization.

3. Administration of thyroid seems to influence the course of the infection favorably.

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An early cancer of the breast is usually a local cancer and thereby a curable cancer, if properly managed.

Emotional Factors in a University Setting

By Benjamin B. Stamell, M.D.
Detroit, Michigan

WHAT ARE the emotional problems facing the student when he comes to a university? What are the social and emotional adjustments he must make before he advances to a greater maturity?

With seventeen or eighteen years of life experience, the student enrolls in the university. What these experiences have done toward making him a well-integrated personality, how willingly and how eagerly he has entered upon the last period of academic training are factors of great importance in his final preparation of meeting life as an adult.

In addition to the usual social and academic stresses facing the student today is the impact of social unrest and the fluidity of sovereignties and national governments, which accords a feeling of insecurity to all peoples. The strains and dislocations that accompany war and world travail are reflected in uncertainties in the behavior of the young people who most certainly bear the brunt of the cataclysm. It therefore becomes a greater problem for their developing personalities to accommodate and adjust to an unstable environment.

It is not the purpose of this paper to enter into a discussion of the tensions manifested by a world at war, but to consider the elements of the milieu that the post-adolescent and young adult must face when he enters a university. However, notice must be taken of the fact that the environment of the college student is no longer a comfortable and secure four-year period of gradual adjustment.

Usually, entrance into a university catches the student in transition from adolescence to adulthood at a time when he is experimenting with many attitudes, feelings and convictions. Physical growth has been sporadic and unequal. Mental growth is inconsistent and unpredictable. The student is generally unaware of his capacities. Before he is fully conscious of any one aspect of himself as dependable and understandable, he finds himself caught in dozens of other relationships, in none of which does he feel any real security.

The student comes from an outside world in which out of his own frustrations and emotional needs he has built up many symptoms. As he learns to understand himself and others sufficiently well, he is called upon to make further adjustments upon the college campus. The great concern of the faculty is that the student mature emotionally to the fullest extent and profit by his four years of university training. Learning is undoubtedly a feeling process. The student, affected by his emotional conflicts, cannot learn unless he has settled the problems that are troubling him personally, thus leaving him free to take in material from his textbooks and instructors.

The physical separation from home life, like the psychological weaning from the family, is of extreme importance to the student on most campuses. Where at one time his dissatisfactions with his family were many, his sentimental attachments are still numerous and strong. Even when the family is scorned for its conservatism or its lower economic or social standards or its narrow ethical principles, it may still be sought as a safe haven from the too insistent competition of campus life. It is not difficult to find on any campus the student that is struggling with a family at once too critical and, at the same time, too sympathetic. Also, quite as provoking and also more harmful is the dissatisfied parent who is aloof and disapproving, and sometimes even actively antagonistic.

At an urban university, the student who lives at home during his college years is more frequently faced with this particular dilemma. He will lack the freedom which students attending an out-of-town school enjoy so carelessly, and for him the conflict between the older and the younger generation, between his family and the campus standards, are all the more obvious and inescapable. The young person invariably looks forward to garnering more and exciting new experiences, and his parents look back in the light of their own painfully acquired experience, and a conflict ensues. The student will be preoccupied with his struggle for independence, especially in minor details of his life. His wrong steps, his unsuccessful experiments are observed continuously by his parents. Every thought and action must be endlessly explained and defended.

Behavior symptoms may then become evident. Unexpressed or expressed anxieties, and aggressions

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may occur. The student may be haunted by his fear of failure, and he may find it difficult to face the inadequacies that lie deep within himself, or that he dare not face frankly or express. Hostility may become apparent in his attitudes toward his family, schoolmates, and the general community. He may fear becoming openly hostile and have recourse to physical complaints and symptoms that have no organic basis but that gain for him, if only momentarily, protection, freedom from responsibility, and emotional satisfaction from his family.

Every university is a meeting place for many cultural elements. Students come from all walks of life, all levels of intelligence, and from widely scattered geographical areas. New and different religious and political beliefs are encountered for the first time. Manners, morals, and social attitudes that have always been taken for granted are challenged, sometimes pleasantly and gently, and sometimes with stinging shock. To some the wider horizon is awesome and stimulating; to others it is fearful and foreboding.

Social drives during college years are extremely important, for social life plays a significant role in the development of the individual in his formative years. For every student the establishment of his place and his general acceptability within home and campus groups must somehow be accomplished. The poise which the young adult counts as of such great importance is founded on social approval in childhood and subsequently through experience and practice of social skills. This need for acceptance and approval must be met to satisfy the budding personality.

As in the family, there is a mental and emotional climate in the university, and personalities will remain whole and healthy as long as a situation remains fairly favorable. When the environment becomes uncongenial or too demanding, conflicts develop. On the college campus especially, the sensitive individual meets for the first time the considerable stresses and strains of adult life.

Most college students desire an easy give-and-take relationship with their fellows. The socially insecure, however, manifest their agonies in many ways. The student who acknowledges his need for social activities may not be able to accept the opportunities when they are given him. The individual who is conspicuous by loud behavior at a campus hangout may be bravely attempting to conceal his non-acceptance in a desired group. Withdrawals from school may occasionally be the result of a failure to receive a bid from a sorority or fraternity. The ability to make friends may also make the difference as to whether or not a student stays in school.

The establishment of satisfactory heterosexual relations is of prime importance. This quite obviously does not always run a smooth course. The adolescent and the post-adolescent phases are times of crushes and over-dependency. Many college students have not totally emerged from this period. Adjustment to the opposite sex is difficult and arduous for quite a number of them. This is true for both the married and the unmarried. When marriage has a solid foundation in the case of students, its sobering and stabilizing influences are often noted in the students' performance. But if a marriage is unhappy, it can either be the cause or the result of a personality problem.

How, then, can these young people be helped in the university mental hygiene clinic? What are the symptoms that suggest the need for referral to a guidance counselor?

It is essential that genuine sympathy and understanding in emotional terms be an attitude of the counselor. The student quite obviously must be met at his own particular level of development. It should be recognized that the mores of his generation, his moral codes, his speech habits, his life values, and his social handicaps, and his aspirations are a necessary part of his personality. A comprehension of all elements of the personality makeup of the student is important in determining a possible solution to his problems.

To become aware of the difficulties and the needs of a student requires observation from more than one angle and on more than one occasion. It is easy for an instructor in a university to think of his students in terms of grades or in terms of a certain tractability in the classroom. However, the internal problems which the student faces are situations of which the instructor may be entirely oblivious.

In determining the need for special attention, it cannot be too strongly emphasized that no one symptom can be taken as an inevitable indication of maladjustment. More information, in order to ascertain whether or not a symptom is a definite characteristic of that particular individual, should be obtained. Thus, a single observation of a slightly elevated temperature does not warrant a diagnosis of illness. An individual may normally maintain a slightly higher body temperature than

the average; and if there are no signs of physical illness, it would be unwise to become unduly concerned. It is the symptom complex, not the isolated symptom, that should be considered. A knowledge of the background, history, and culture patterns of the student is then necessary.

When flagrant emotional illness asserts itself, a moderately intelligent person with no particular training may quickly become aware of the condition. However, it requires more training and acumen to detect these illnesses in their incipiency, and at a time when preventive measures can be instituted. More than that, it is assumed that it is desirable, if possible, to facilitate a better adjustment rather than letting the student sweat it out by himself.

In judging the need for special attention, some recognition must be taken of the individual's appearance, performance, and relationships with other students, as well as what he says himself. Signs of tension may be manifested by restlessness, irritability and impatience, and occasionally a drive to work beyond capacity or conversely to throw in the sponge and get away from it all by bolting classes and by sporadic attendance. The "eager beavers," the perfectionists, are fertile soil for investigation because of their rigid standards as well as the students who do poorly in their work. The serious, over-meticulous, exact individual may be headed for an emotional breakdown more quickly than the lively, nonchalant individual who takes his classwork with a grain of humor.

Indecision, inefficiency and inability to concentrate are common complaints and require further investigation in order to determine their significance. If indecision extends to all routines of living, it can be assumed that a profound emotional situation exists. It should be noted that the domineering, chronically aggressive person has such a high nuisance value that help is sought for him more quickly than for the reticent, socially inert person, whose difficulty renders him inconspicuous. However, it may be that the withdrawn person is more in need of assistance and is less able to procure it for himself.

Daydreaming and other signs of withdrawal may mean only temporary preoccupation; but when normal activity is interrupted for any length of time, then it is an unhealthy sign. Sudden incongruous and unaccountable changes in behavior like cutting classes, declining grades, and shifts in programs may be indications of disturbance. Inappropriate giggling and laughter as well as frequent sighing and bored expressions may be transitory but in conjunction with other symptoms may be part of a more serious state. An apathetic or indifferent attitude may portend a morbid state of mind or it may be a cover-up for great anxiety.

Peculiar mannerisms, jerking movements, and muscular spasms are as often manifestations of long-standing maladjustments as they are of neurological disorders. Cheating, lying, stealing, and violations of the law are not infrequent behavior disorders, and are indications that a careful study of the individual is required. Behavior, it may be readily apparent, is the resultant of many forces, both external and internal. Variation in mood is expected of all individuals and quite often parallels physiological states. Some persons recognize and have learned to accept periods of let-down and decreased efficiency, while others are alarmed unduly at the variation. When the extremes are so great as to alter behavior and to prevent the individual from acceptable performance for appreciable lengths of time, the change can be said to be significant. Mood often can be inferred from facial expression, manner of speech, and statements of inadequacy or worthlessness. Mood swings that are not explainable or represent departures from the usual pattern, as well as absence of emotional response are indications that the student needs treatment. Mood that is inappropriate to thought processes and to the situation may be a sign of serious mental illness and suggests need for further study.

That emotional difficulties can be translated into physical complaints has long been recognized by the medical profession. Lately this has been reemphasized, and the lay public has become increasingly aware of this factor. The concern over physical sensation and ailments varies with the individual and in the same individual at different times. Student health services usually experience a marked upsurge in dispensary calls at examination time. It is recognized, of course, that other hygienic factors add to the total load which the student carries at this time. Physical distress is an accompaniment of practically all forms of mental illness, and many symptoms have a basis in demonstrable physiological changes.

The problem of therapy for students is undeniably complex. The correction or prevention of personality distortions that express themselves in

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Differentiation of Dyspnea Caused by Cardiac Disease from Dyspnea Associated with Pulmonary Emphysema

By Richard V. Ebert, M.D.
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THE PROBLEM which I am to discuss here is the diagnosis of the middle-aged or elderly patient with dyspnea. Shortness of breath is a common symptom and is usually attributed to failure of the heart. It must be remembered that dyspnea is primarily a pulmonary symptom and is produced by diseases which interfere with normal ventilation of the lungs.

Pulmonary emphysema is a common cause of dyspnea in the older age group. It is often diagnosed incorrectly as heart disease. There are several reasons for this. In the first place the presenting symptoms are similar. Dyspnea is the chief complaint in both diseases. The physical findings in pulmonary emphysema may be obscure, leading the physician to a diagnosis of heart disease by a process of exclusion. Finally, the patients with pulmonary emphysema may develop right heart enlargement as a result of pulmonary hypertension, and exhibit the signs of right heart failure, namely, distended neck veins, hepatomegaly and edema.

An accurate differentiation of pulmonary emphysema from primary heart disease can usually be made by careful attention to certain details of the history and physical examination. Contrary to what one might suppose, the nature of the dyspnea is of little aid in differentiating cardiac from pulmonary dyspnea. Paroxysmal dyspnea and nocturnal dyspnea are common in both disease states. Patients with emphysema often breathe most comfortably in the sitting position as do patients with cardiac failure. The duration of the dyspnea is of some importance. Patients with emphysema will often develop exertional dyspnea gradually over a period of years, while patients with heart disease usually have a more abrupt onset of this symptom. Cough is an almost universal symptom in patients with emphysema and is usually of long duration, often preceding the onset of dyspnea. In heart failure cough is usually not a conspicuous symptom.

Examination is of greater aid in diagnosis than is history. Visible cyanosis may or may not be present in either disease. Intense cyanosis occurs more commonly in pulmonary emphysema than in primary heart disease. For this reason patients with pulmonary emphysema and cor pulmonale have been called black cardiacs. Most patients with pulmonary emphysema will exhibit a barrel chest. Unfortunately this configuration of the chest is not specific for emphysema. Many elderly persons will have an increased anterior posterior diameter of the chest and a rounded kyphosis of the thoracic spine and yet exhibit relatively normal pulmonary function. For this reason this sign must be interpreted with some caution. The same is true of hyperresonance of the chest and obliteration of cardiac dullness. Of more importance is the marked limitation of motion of the chest on use of the accessory muscles of respiration in patients with emphysema.

Of greatest importance in the physical examination is the detection of cardiac enlargement. Patients with heart failure as a cause of dyspnea will almost always present evidence of cardiac enlargement. Patients with emphysema will not show evidence of cardiac enlargement on physical examination even though there is right heart enlargement present in the roentgenogram of the chest. Enlargement of the heart is best detected by palpation of the apex impulse. The presence of significant murmurs, gallop rhythm, or auricular fibrillation should lead one to suspect that dyspnea is on a cardiac basis.

Roentgenographic and fluoroscopic examination of the chest may be of greater value. The characteristic finding in pulmonary emphysema is low flat diaphragms which move poorly in fluoroscopy. The heart is usually vertical in type and not enlarged. If cardiac enlargement is present, it is primarily of the right ventricular type. At times bullae can be visualized in the roentgenogram of the chest. In dyspnea of cardiac origin the heart is almost invariably enlarged and the enlargement is usually of the left ventricular type. In mitral disease the enlargement is of the right ventricular type and the roentgenographic picture may be similar to that seen in pulmonary emphysema with cor pulmonale.

The electrocardiogram in pulmonary emphysema is normal or may show evidence of right

Presented at the eighty-sixth Annual Session of the Michigan State Medical Society at Grand Rapids, September 28, 1951.

ventricular hypertrophy or positional change. The circulation time from arm to tongue is usually normal in patients with pulmonary emphysema and prolonged in patients with dyspnea on the basis of heart failure.

The differentiation of cardiac failure from pulmonary emphysema can be most reliably made by studies of the total lung volume and its subdivisions. In pulmonary emphysema the vital capacity is reduced and the residual air is markedly increased. The total lung volume is normal. In heart failure the vital capacity is reduced as is the total lung volume. The residual air is normal. While the measurement of residual air and total lung volume requires special techniques, a great deal of information can be obtained by the measurement of vital capacity. The vital capacity in emphysema is usually reduced to a greater extent than in heart failure. More important, the expiration of air is very slow, while in heart failure the air can be expelled rapidly. The determination of the vital capacity can be done in the office or at the bedside with a simple portable device.

A final point in differentiation is the carbon dioxide content of the blood. In pulmonary emphysema there is impaired ventilation of the alveoli and the carbon dioxide tension of the blood rises. The bicarbonate of the blood increases to compensate and maintain a normal P_h. In heart failure, on the other hand, the excretion of carbon dioxide is normal.

The importance of the differentiation of the dyspnea of heart failure from the dyspnea of pulmonary emphysema lies in the treatment of the patient. Morphine is a most useful drug in controlling the paroxysms of dyspnea in congestive heart failure. It is a lethal drug in pulmonary emphysema. This is because by depressing respiration it accentuates the anoxia and carbon dioxide retention which are present. Oxygen therapy may correct the anoxia, but the patient may die from accumulation of carbon dioxide and respiratory acidosis. The use of antibiotics to control bronchial and pulmonary infection may greatly aid patients with emphysema. Bronchodilators may also offer relief of symptoms. On the other hand, digitalis is of no value unless right heart failure is present.

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FEDERAL LEGISLATION

(Continued from Page 826)

or amended proposals will need special Health and Welfare Committee approval.

* * *

AEC to Charge 20 per cent of Production Costs for Isotopes Used in Cancer.—Effective July 1, the Atomic Energy Commission will charge 20 per cent of production costs for radioisotopes for use in the study, diagnosis or treatment of cancer. Since 1948 when distribution of isotopes started, AEC has charged full production, handling and shipping costs for isotopes to be used in *other medical research or treatment,* but has waived production costs on those to be used in *cancer.* Explaining the changed policy, AEC said:

"The field has developed so rapidly that certain clinical applications of radioisotopes now have become a matter of routine, and research workers have become fully aware of the usefulness of these atomic tools in cancer research . . . The stimulus of completely free distribution no longer is necessary to encourage the use of radioisotopes in the field of cancer."

For use on cancer, the price schedule will be fifteen cents per millicure for radioiodine 131, twenty-two cents for radiophosphorus 32, five cents for radiogold 198, twenty cents for radiocarbon 14.

* * *

Senate Subcommittee Considers Restrictions on International Treaties.—A Senate Judiciary subcommittee currently is holding public hearings on S.J. Res. 130, designed to prohibit international agreements which interfere with constitutional rights of U. S. citizens. The resolution was introduced by Chairman O'Conor (D., Md.) of the subcommittee and fifty-four other Senators, including Senator Bricker (R., Ohio), who testified before the subcommittee. Senator Bricker, pointing out that the legislation is directed primarily at the Covenant on Human Rights being drafted by the UN's Human Rights Commission, noted that among other things that covenant undertakes to enact legislation which will "assure the right of all to medical service and medical attention in the event of sickness." Once approved by the Senate, treaties become the law of the land.

GAINS IN LIVING STANDARDS

Millions of Americans have made remarkable gains in living standards during the past ten years according to a study made by Dr. Simon Kuznets of the University of Pennsylvania. There is a redistribution of the national income. The very poor have been reduced in numbers by two-thirds. In 1939 three out of every four families had incomes less than $2,000. In 1949 one out of three were in the same group. The well-to-do and the rich have become more numerous. In 1939 one family in fifty had an income over $5,000, and one in 100 earned over $10,000. These rates as of 1949 were one in six and one in twenty.

Neurodermatitis (Atopic Eczema)

Concept and Functional Aspects

By Stephen Rothman, M.D.

Chicago, Illinois

IN DISCUSSING neurodermatitis, a disease entity of unknown etiology and of a poorly understood pathomechanism, I believe that it may be useful to start out with a historical analysis of the two synonyms by which this condition is most frequently designated: atopic eczema and neurodermatitis.

The term atopic eczema was coined by A. F. Coca in 1925. His conception has been that this disease is a special form of allergic hypersensitiveness, not having a single cause-single effect mechanism as is the case in eczematous contact-type dermatitis, but being based on an inherited constitution with multiple dermal sensitivities and multiple sensitivities of the mucous membranes; therefore, association of atopic eczema with asthma and hay fever is common in the individual and in his ascendents. It has been to the credit of Coca that he clearly stated that patients of this group have a particular constitution, which is inherited. However, he and his followers did not succeed in proving that the cutaneous manifestations of this constitution are allergic in nature. There is no proof that the multiple dermal sensitivities, demonstrable by scratch and intradermal tests or by the presence of antibodies, have any relation to the skin disease itself. A positive skin test becomes etiologically significant for a dermatosis only if contact with or administration of the incriminated substances provoke specific skin lesions, if after the elimination of these substances the eruption clears up promptly, and if such experiments can be repeated at any time and under all circumstances with the same unequivocal result. This is not the case with atopic dermatitis. On the contrary, all clinical dermatologists know a great number of cases in which the patient goes on for years avoiding incriminated foods or contacts without any effect on the course of his skin disease.

One can imagine an allergic disease with a multitude of ubiquitous or almost ubiquitous allergens such as components of dust, or, among food stuffs, proteins in general, which never can be completely eliminated. However, such an assumption in the case of atopic dermatitis is purely hypothetical. At present, the only observation which might support this hypothesis is that change in environment often brings about complete remission. However, others use the same argument to prove that atopic eczema is a functional disease because change of environment brings about changes of job, of bosses, of neighbors and, what seems particularly important, in personal problems, it often brings about separation from the family. You see how different the interpretation of the same observation can be. Obviously, one will have to study the effects of environmental changes more closely, under more precisely set experimental conditions, before one will be able to draw valid conclusions. So far, observations have been made in a rather haphazard way and often with a preconceived opinion. The complex "environmental change" never has been taken apart into single elements and studied by varying these elements. We have "impressions" only. My impression, for instance, is that change of environment is most effective if the patient moves to a sunny, warm, dry climate.

There is a particular difficulty to correlate dermal sensitivities to the clinical picture of atopic eczema. Atopic eczema is a primarily epidermal disease, whereas the multiple sensitivities are dermal, demonstrable by scratch and intradermal tests and not by patch tests. It is a notorious fact that atopic patients become sensitized to epidermal allergens with greater difficulty than normal persons. Becker finds that epidermal sensitivities never occur in atopic eczema. Atopic eczema may be an allergic disease but the evidence for it is still lacking.

The name "neurodermite" was first used by L. Brocq and L. Jacquet in 1891. Originally, the name meant that itching is the primary phenomenon which precedes visible cutaneous changes. The authors assumed that there must be a "paresthesia," an abnormal sensation due to an abnormal sensory impulse, and, therefore, neurodermatitis is of nervous origin. It was not specified by these authors whether they meant an organic nerve disease or a disturbance in the psychic sphere. At about the same time, however, another French author, H. Leloir, quite clearly separated these

Presented at the eighty-sixth Annual Session of the Michigan State Medical Society, Grand Rapids, September 26, 1951.

two possible mechanisms. He said that there are, firstly, "reflex dermatoneuroses due to a simple and transitory excitation of nervous centers secondary to peripheral nervous irritation" and, secondly, "dermatoneuroses caused by moral shock." It is perhaps worthwhile to mention that "moral shock" as an etiologic factor was mentioned as early as 1855 by Canuet, a pupil of Cazenave.

The neurogenic theory of neurodermatitis was further developed by C. Kreibich, who published his famous work on angioneurotic inflammation in 1909. His theory is based on the observation that there are exaggerated vasomotor responses to any kind of local stimulation in neurodermatitis. He carried his "angioneurotic" theory of exaggerated vasodilator response to sensory stimuli so far as to claim that sensory impulses arising in an irritated lesion may be projected by long reflex processes to symmetrical or other distant areas where inflammatory lesions will arise by nervous impulses alone without intervention of any external stimulation. Kreibich ignored the results of physiological experimentation which indicates that permanent inflammatory lesions cannot be produced by autonomic nervous impulses. However, it was Kreibich's merit to point out the participation of friction and scratching in the development of lesions and the abnormality of the response to such mechanical stimuli in neurodermatitis.

In its most modern form the theory of nervous origin of neurodermatitis was originated in this country by Stokes and developed thoroughly and in great detail by S. W. Becker. They have described the emotional instability of the patients suffering from neurodermatitis, their unusual tenseness, and the two main personality types, the overactive or overambitious and the worrying type. These authors have the great merit of having shown that the emotional tension, as well as the itching and eruptions of these patients, are greatly benefited by administration of sedatives, by carefully dosed rest periods and by a simple (I almost would say primitive) psychotherapy—giving the patient insight into his tenseness and advising him how to get out of it ("don't give a damn" program of Stokes).

The work of Stokes and of Becker brought about a clinically highly significant progress in the rational management of the disease. Nonetheless, the modern "psychosomatic" concepts of neurodermatitis (including the psychoanalytic approach) did not further elucidate the etiology and pathomechanism of the disease. The labeling of neurodermatitis as a functional disease does not give an answer to the important question: through what mode of action do emotional factors create the eruption? We know that the course of the disease can be influenced by modifying the psychic attitude. This indicates that psychic factors play a role, primary or secondary or tertiary, in the course of the disease, but it does not mean that the disease originates in the psyche as do functional bowel distress or cardiac neurosis, in which exaggerated autonomic impulses originating in the cortex perfectly explain all signs and symptoms.

Such functional neuroses are well known to occur also in cutaneous pathology, the best examples being functional hyperhidrosis, functional vasoneurosis and in a somewhat different way the quite unique picture of cholinergic urticaria, in which normal antidromic vasodilator impulses lead to the appearance of fleeting inflammatory eruptions because the skin is hypersensitive to acetylcholine, the otherwise normal tissue product of this impulse. However, as indicated above, hitherto it has not been demonstrated that psychic impulses in themselves are capable to produce stable inflammatory lesions as we see them in neurodermatitis.

A primary faulty sensation of itching, of course, may be purely psychogenic, and the scratching or rubbing following this sensation can provoke inflammatory lesions. By repeated itching-scratching spells, the relatively mild and unstable scratch reactions may be aggravated and become permanent. The lesion may enlarge in size and become more and more severe in the degree of inflammation and degree of epidermal injury. This is the concept of scratch eczema or frictional eczema of Kreibich, and there is much to say in favor of this conception.

Firstly, there is the old contention that lesions of neurodermatitis start out with itching sensation without visible changes, and this is confirmed by free admission of many of our patients. They sometimes express this experience by saying that they are able to predict where the next new lesion will appear. Secondly, we know that neurodermatitis lesions itch and are scratched or rubbed beyond proportion to their clinical appearance. Thirdly, itching, as any other cutaneous sensation, may arise in the cerebral cortex either without any event in the periphery as a purely "functional"

symptom or in response to sub-threshold peripheral stimuli because of hyperexcitability of the cortex. In normal individuals, everyday stimuli to the skin, such as slight friction, pressure, release of pressure, or temperature changes, evoke the so-called minimal pruritus which does not enter or hardly enters the consciousness and is taken care of with a few rubbing movements due to subcortical reflexes or remains entirely without response. Apparently, sensations of the same intensity evoke violent scratching in neurodermatitis patients. This may be called "conditioning to itching and scratching" and could be very well a consequence of the emotional make-up of the patient if we admit that such make-up is already evident in early infancy, because this conditioning starts with the infantile eczema.

This concept would imply that all lesions of neurodermatitis are purely factitial, results of rubbing and scratching, and this cannot be true for all lesions—not, for instance, for the nummular lesions of exudative neurodermatitis ("nummular eczema") because the circular shape and sharp limitation of these lesions is incompatible with the assumption that they are scratch or rub effects.

Even if we disregard nummular eczema as a quite particular manifestation, possibly not belonging to neurodermatitis, and if we consider the diffuse lesions only, and claim that they are effects of rubbing and scratching, we still cannot regard neurodermatitis as being of purely functional origin as we do regard neurotic excoriations or hysterical self-induced lesions. Somatic elements come into the picture with the abnormal reactions to mechanical injury. In exudative neurodermatitis there are exaggerated vasodilator response and increased vulnerability of the epidermis; they lead first to the état ponctueux (status punctosus) of Devergie and then to oozing and crusting in response to relatively mild traumatization. In dry neurodermatitis lichenification develops; this is an abnormal tissue reaction to chronic rubbing which cannot be provoked experimentally in normal persons. The best clinical example to illustrate this point is pruritus ani. About one-half of the pruritus ani patients have no atopic history; they had no infantile eczema, no dermatitis, no asthma, no hay fever—neither themselves nor their ascendants. They readily admit having rubbed their anus for years, but they do not develop lichenification. When a neurodermatitis patient starts to complain of pruritus ani, he develops severe lichenification within a few weeks.

Exaggerated tendency to exudative reactions and lichenification tremendously facilitates the development and permanence of the itching-scratching cycle, because both states—lichenification more intensely—decrease the itching threshold, i.e., increase itching hyperexcitability to external stimuli.

On the other hand, these somatic abnormalities are again greatly accentuated by psychic influences. By the emotions of distress, self-pity, uneasiness and apprehension, arteriolar hyperemia is induced into inflammatory lesions via antidromic vasodilatation. This hyperemia also decreases the itching threshold and increases itching susceptibility. Thus the itching-scratching cycle is indeed a psychosomatic affair.

Recapitulating, the most important features of the disease we can list are emotional instability and increased conditioning to itching and scratching, on the psychic side—abnormal tissue reactions to mechanical stimulation, multiple cutaneous and mucous membrane sensitivities, on the somatic side. If we add that these features are familial and that in many cases they become manifest in early infancy, it seems that the common denominator of all these psychic and somatic features is a particular inherited constitution. I am aware that this concept is atavistic, and falls back on the old prurigo diathesique of Besnier, but nevertheless, it is the only interpretation which harmonizes with all the known facts. It implies that the disease has no etiology in the sense that infection, metabolic disturbances, allergic conditions or functional diseases have, but it rather can be compared to genetically induced abnormalities in both the psychic and somatic spheres.

If it is true that neurodermatitis is not an etiologic entity but a constitutional anomaly, the best we can hope for in its management is its improvement by symptomatic treatment along both the psychotherapeutic and the dermatotherapeutic lines.

If it is true that neurodermatitis patients are not made but born, the basic concept of psychoanalysis on neuroses cannot be applied to their case. Their anomaly does not develop from repression of early adverse experiences or from psychic traumata of any kind. On the contrary, it does not make any

(Continued on Page 877)

Observations of the Efficacy of Chloramphenicol (Chloromycetin) and ACTH in the Treatment of Typhoid Fever in Children

A Report of Two Cases

By Irving F. Burton, M.D., and
Mary McDermott, M.D.

Detroit, Michigan

OF THE chemotherapeutic and antibiotic agents available for the treatment of typhoid fever, chloramphenicol (Chloromycetin®) has been reported the most effective. Following the original report by Woodward in 1948, a series of papers[6,9] were published which in most instances have been enthusiastic concerning the use of chloramphenicol in the treatment of typhoid fever in adults. More recently, relapses following such therapy have been reported as well as its relative ineffectiveness in eradicating typhoid bacilli in carriers.[8]

Selingman and Wasserman[4] report that although chloramphenicol exerts a marked inhibitory effect on the growth of salmonella organisms *in vitro*, the drug, even in large amounts, is incapable of controlling salmonella infections in mice.

Ross[3] reported poor results in the treatment of salmonella enteritis, other than typhoid, in infants. After prolonged treatment with chloramphenicol the stools of seven of nine patients which were negative for salmonella during the period of treatment became positive shortly after stopping the drug and the organisms recovered were highly sensitive to chloramphenicol again.

An editorial in the *New England Journal of Medicine*[1] suggests that the organisms are either inaccessible to the antibiotic or in some way they are protected from its action.

Recently Greengard[2] reported seven cases of typhoid fever in children treated with large doses of chloramphenicol, .070 gm. to .140 gm. per kg. every twenty-four hours. It was felt that improvement in five cases was due solely to the treatment, while two cases improved coincidental with the beginning of therapy.

From the Pediatric Division of Harper Hospital, Detroit, Michigan.

During the fall of 1951 we treated two cases of typhoid fever in children, one with chloramphenicol and one with chloramphenicol plus ACTH. Because of the relatively few cases reported in children and the dramatic course of the disease in the instance where ACTH was used, it is believed our observations may be of interest to others.

Case 1.—E.R.S., a seven-year-old white boy, was admitted to the Harper Hospital Pediatric service on August 24, 1951, with the complaint of cough, fever, diarrhea, abdominal cramps, sore throat and headache. The onset began abruptly two weeks prior to admission with fever and coughing. He was seen one week later by his physician and a diagnosis of pneumonia made. He received an initial dose of 400,000 units of aqueous procaine penicillin and oral chloramphenicol, 50 mg./kg. per day. He seemed much worse in the following week and was seen by one of us and hospitalization advised.

The past history was irrelevant except that he had been swimming in the local public pools and in the Detroit River during the summer. Similar illness was not found in the family or his companions. Physical examination revealed an acutely ill child with moderate dehydration. The liver and spleen were palpable 3 cm. below the costal margin. The abdomen was slightly distended and there was exquisite tenderness in the right upper quadrant. A few fine râles were heard bilaterally throughout the chest with occasional wheezing. The pharynx was slightly injected.

The clinical course, laboratory studies and treatment are outlined graphically in Figure 1. Although a tentative diagnosis of typhoid fever was made, a positive diagnosis was not made until the fifth hospital day, when the agglutinations became positive, and the stool culture was reported as positive on the eighth day for S. typhosa.

The child received supportive treatment, and chloramphenicol, 50 mg./kg. body weight, was given in divided daily doses. An x-ray of his chest on admission was essentially normal. A flat plate of the abdomen showed moderate distention of both small and large bowel with a slightly enlarged spleen. Our chief concern was with his distention and exquisite pain in the upper right quadrant. This persisted until the twentieth hospital day. He was seen by Dr. Clifford Benson of the Surgery Department, who felt that the distention was that of adynamic ileus and therefore recommended a conservative program. It is interesting that the child had an almost persistent leukocytosis throughout. He was discharged on the twenty-sixth hospital day. Follow-up stool cultures were all negative.

Case 2.—S.A., a five-year-old white boy, was first seen by one of us in consultation in another hospital. This child had visited an epidemic typhoid area in Sicily one month previously. He had received no typhoid immunizations. Three days prior to admission he complained of a sore throat and had a temperature ranging up to 103° F. He was given daily injections of 400,000 units of aqueous procaine penicillin at home, but as he seemed worse, he

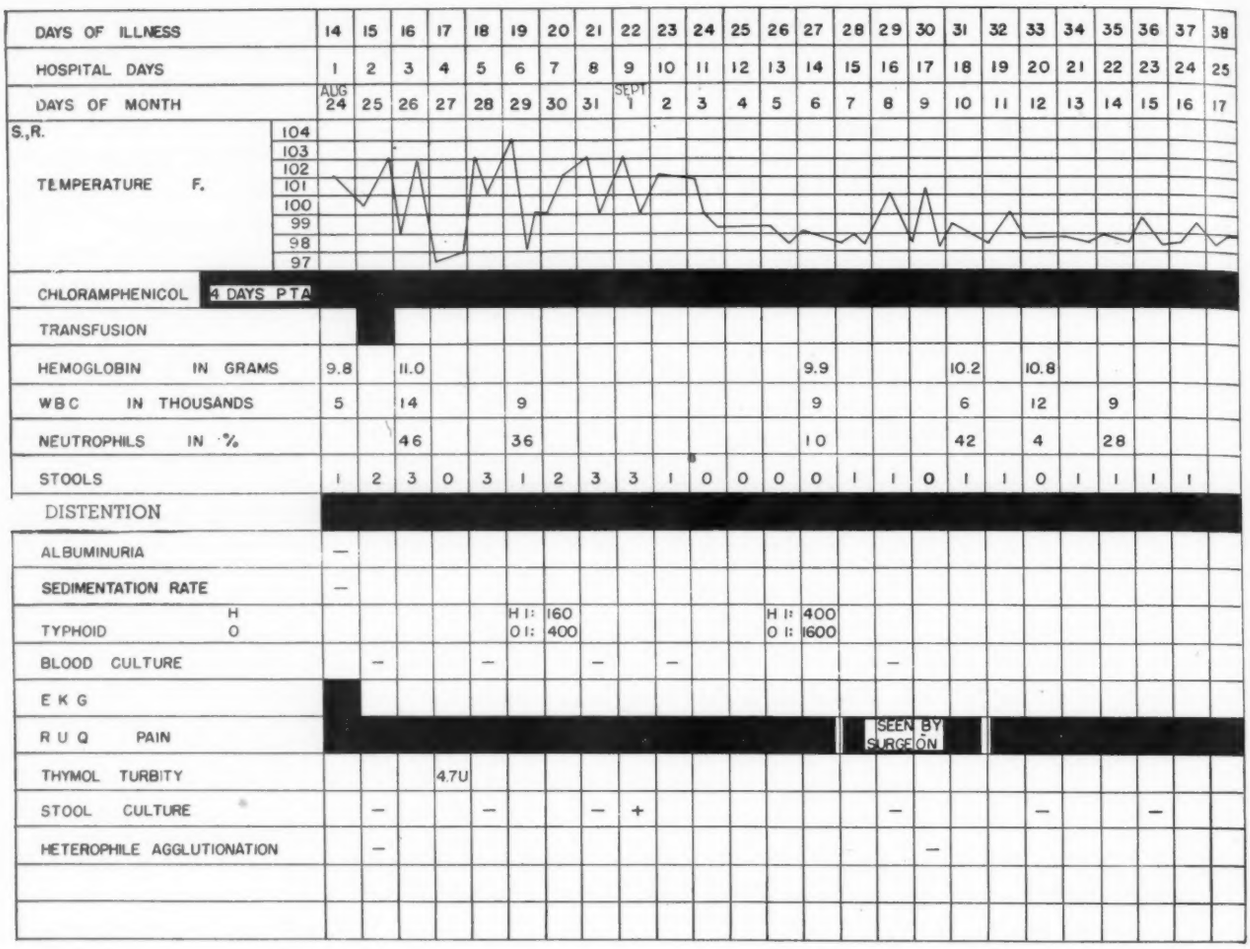

Fig. 1.

was admitted to the first hospital. Physical examination revealed an acutely ill, nearly moribund child with severe dehydration, acaphoid abdomen, marked sordes and nuchal rigidity. Temperature was 106° F. and required considerable nursing to keep it from rising higher. Liver and spleen were only slightly enlarged. The pulse was rapid. A lumbar puncture showed a normal spinal fluid. Agglutinations for typhoid were positive, 1:1280 for the H and O antigen. The initial blood culture was reported as positive for S. typhosa on the fourth hospital day. He was given supportive treatment and started on chloramphenicol, 50 mg./kg. body weight in divided doses. When the diagnosis was confirmed on the third hospital day, transfer to Harper Hospital was advised.

His condition became so critical that on the second day at Harper Hospital he was given ACTH intramuscularly, 20 mg. every twelve hours for four doses and then 10 mg. every twelve hours for the next three days. His temperature dropped rapidly and he became responsive within forty-eight hours. Three days later, he was totally afebrile. The clinical progress and laboratory data are shown graphically in Figure 2. Abdominal distention and discomfort disappeared on the ninth hospital day. On the seventh hospital day, a shower of rose spots appeared and remained for three days before fading. A small area of alopecia of the scalp was noted on the tenth day. An electrocardiogram taken on the tenth day showed myocardial damage but no conduction defects. This child also showed a moderate leukocytosis persistently. His course thereafter was uneventful and he was discharged on the twenty-first hospital day. Three weeks after discharge, a stool culture was reported as positive for S. typhosa. Another two weeks' course of chloramphenicol was given and subsequent stool cultures for three months have been negative. Agglutinations for typhoid taken on the mother and the uncle of this boy, who were on the same trip with him, were negative.

Comment

In each case, a positive stool culture and in one case a positive blood culture was obtained on admission—the first case after one week and the second case after three days of chloramphenicol treatment, on the basis of 50 mg./kg. body weight per twenty-four hours.

Many of the complications described in typhoid fever developed while they were under chloramphenicol treatment. The first case had a moderately severe bronchitis and persistent ab-

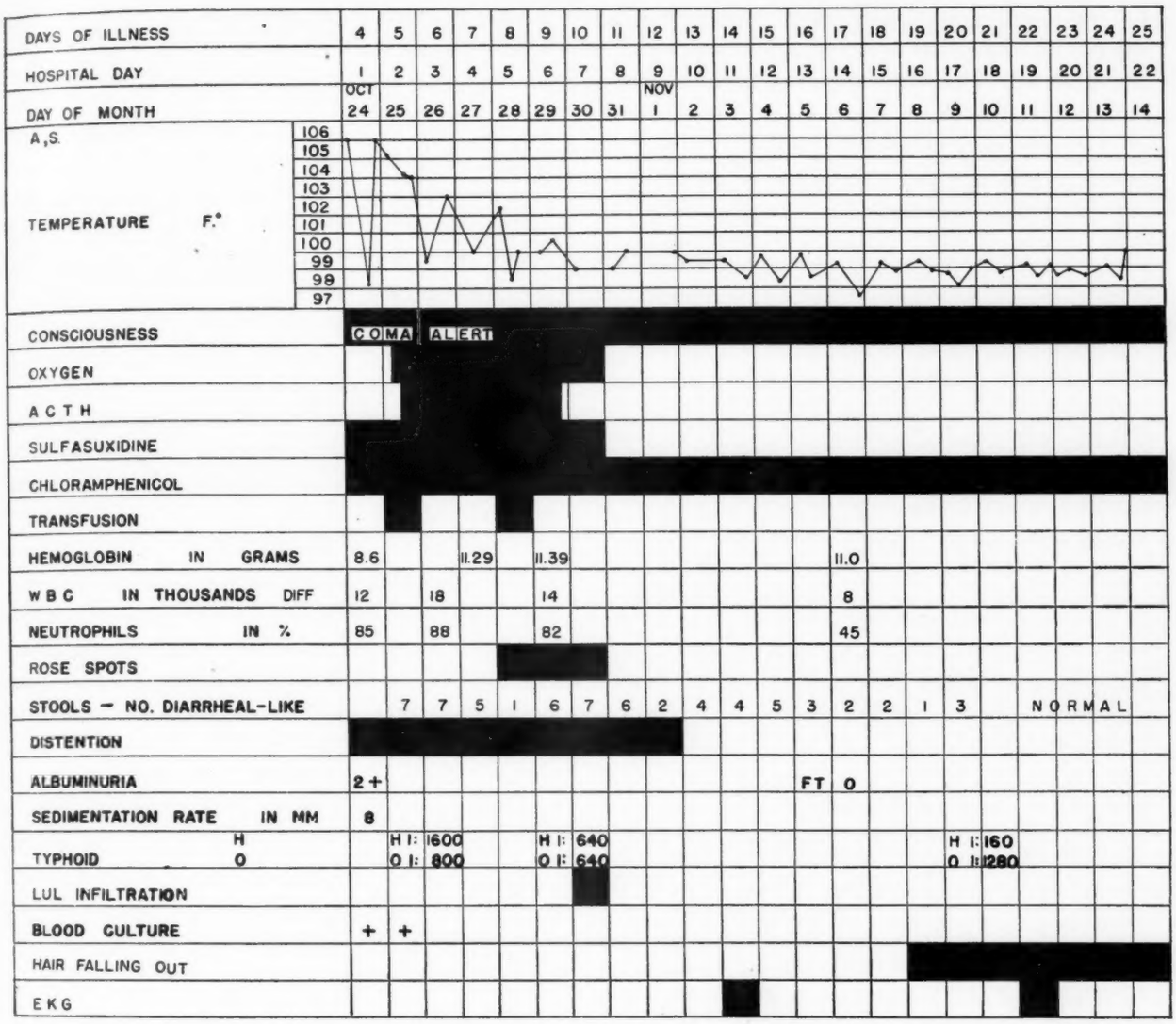

Fig. 2.

dominal pain and tenderness especially in the right upper quadrant. A positive stool culture was found after twenty-two days of illness. The second case had symptoms of a moderately severe upper respiratory infection, meningismus, anemia, myocarditis, rose spots, alopecia, delirium and coma. A positive stool culture was found three weeks after discharge.

We do not feel that the course of this disease in the two children was significantly altered by the use of chloramphenicol in the dosage or the mode of administration that was used. Neither the duration nor the severity of the disease seemed to be much different from cases we have seen in children prior to the use of chloramphenicol. These results are similar to the ones described by Selingman and Wasserman in their experiments with mice and by Ross in infants with Salmonella infection.

The organism in the second case was very sensitive to chloramphenicol *in vitro* as tested in our laboratories and at the laboratories of Parke, Davis & Company. The difference between its action on a child and an adult was inadvertently demonstrated by an unfortunate laboratory accident. A laboratory technician from the referring hospital (Case 2) developed typhoid fever two weeks after handling the contaminated urine. On the same dosage of chloramphenicol on a per pound basis, she recovered very rapidly with little ill effects.

The use of cortisone in conjunction with chloramphenicol in the treatment of typhoid had been reported.[5,7] The results have been favorable. ACTH was administered in the second case because

he was moribund shortly after admission. He showed an immediate and dramatic response. This hormone was administered on an empirical basis, but we feel that there may be come rationale for its use. It may very well be that ACTH and cortisone produce the physiologic response in the patient which augments the effectiveness of the drug.

Summary

Two proved cases of typhoid fever in boys of seven and five years, respectively, are presented.

Chloramphenicol in the dose of 50 mg./kg. body weight per twenty-four hours is relatively ineffective in children as compared to adults.

ACTH administration in the one moribund child proved effective as adjunct therapy.

Acknowledgment

The authors gratefully acknowledge the generous assistance of Dr. Edgar Martmer, chief of the Division of Pediatrics, Harper Hospital, Detroit.
Harper Hospital.

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EMOTIONAL FACTORS IN A UNIVERSITY SETTING

(Continued from Page 859)

an uneconomical use of emotional energy is not simple. The basic guiding principle of treatment is the need of the individual and how that need can most successfully be met, rather than the establishment of any special category to which the student's needs must conform. Successful therapy requires skill and sensitivity on the part of the therapist, who must be capable of comprehending the emotional values of the student. An evaluation of both the positive and negative psychological factors facing the student must be accomplished before attempts are made to interpret his problem.

Summary

The student who first matriculates in a university represents an accumulation of seventeen or eighteen years of experience. Stresses and strains from which he had hitherto been protected are brought to bear on him. His reactions to these stresses are largely determined by many previous events. The campus requires a reorientation and a reassessment of values. Some students become confused and require assistance from the mental hygiene clinic. Emotional help can be obtained with the guidance and sympathy of the faculty and medical staff.

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OLD AGE AND SURVIVORS' INSURANCE

A drop in public spending for relief to the needy aged has resulted from the amended Social Security Act of 1950, according to Arthur J. Altmeyer, Commissioner of Social Security. By July, 1951, there were more persons on the Old Age and Survivors' Insurance rolls than were receiving old age relief. The report reveals that there has been a shift of some of the load from public aid to the public insurance system. As of July 1, 1951, there were 112 aged persons drawing old age insurance benefits for every 100 on old age relief. The federal share of public assistance has been cut by about $7 million a month.

The Use of Anti-Hemophilic Globulin in Obstetrics and Gynecology

By F. W. Tamblyn, M.D.
Lansing, Michigan

VAGINAL BLEEDING in certain obstetric and gynecologic conditions is often a troublesome and dangerous manifestation. Recently, anti-hemophilic globulin has been used in some of these problems with satisfactory results—occasionally dramatic. While discussing the problem with physicians associated with the Michigan State Department of Health, the use of this product was suggested, this being a by-product of whole blood.

The following are a few case reports which we believe have enough significance to warrant further use of the above-named product.

Case 1.—Mrs. L., aged thirty-five, had a rapidly growing carcinoma of the cervix, originating in the cervical canal, while the external os looked normal. Radium was inserted and the vagina packed as usual. The patient hemorrhaged profusely on return to her room, and the radium was removed. The patient was packed, using gel-foam, but bleeding continued. She was given three 20 cc. doses of anti-hemophilic globulin in twenty-four hours, and bleeding promptly stopped after the first dose. During her intermittent stay in the hospital until death on October 28, 1950, or six months later, she received this medication on six different occasions. Bleeding was promptly controlled each time. Once at night, she told the interne to give her the "stuff" in the vein, and that would stop her bleeding.

Case 2.—Mrs. K. B., aged forty-five, had been bleeding almost daily for one year. She was admitted to the hospital on August 24, 1951, because of a severe vaginal hemorrhage. On August 25 she was given 1,000 cc. of blood and was packed, using gel-foam. There was bleeding through pack. On August 26 I saw her for the first time. She was given two 20 cc. doses of anti-hemophilic globulin in eight hours. The bleeding stopped. On August 28 radium was inserted, after a frozen section revealed carcinoma of the cervix, and she was given three 20 cc. doses of globulin in twelve hours. On August 29 there was no bleeding. The radium was removed on August 30, with no bleeding. She was discharged on August 31 to deep therapy laboratory.

Case 3.—Mrs. F. F. had been treated since May 12, 1951, for carcinoma of the cervix, with radium and x-ray. She entered the hospital on November 10, 1951, because of pain in the left lower quadrant and partial intestinal obstruction. She bled vaginally on December 7. She was given three doses of 20 cc. anti-hemophilic globulin, and the bleeding promptly stopped after the first dose. No packing was used.

Case 4.—Mrs. E. M. was a nurse, aged twenty-six, gravida 3, para 1. The estimated date of delivery was October 5, 1951. She was given thyroid and stilbestrol during pregnancy. On July 4, 1951, there was vaginal bleeding of 500 cc. She entered the hospital that day, and after the usual bed rest and transfusions, the bleeding gradually subsided in five days. She was discharged on July 11. On September 4 she bled 500 cc., passed several large clots, and was admitted at 12:00 noon, with a diagnosis of partial abruptio. At 12:20 p.m., 20 cc. of anti-hemophilic globulin was given. At 1:30 p.m., the bleeding was subsiding, and it stopped by 2:00 p.m. The globulin was repeated in the evening and on the morning of September 5. She was discharged on September 7. The patient asked, "Why didn't you give me this the first time?" She was delivered of a normal infant on September 30, 1951.

Case 5.—A patient at term entered hospital with severe vaginal bleeding. She was almost completely dilated with a breech presentation. There were no fetal heart tones. The diagnosis was abruptio placenta. The membranes were ruptured and the baby delivered. The placenta was delivered and then 500 cc. of old blood clots came from the uterus. She continued to bleed. The uterus was packed and gel-foam used. Still she continued to bleed. Sub-total hysterectomy was done, and the cervix was closed tightly with figure-of-eight chromic sutures. She continued to bleed vaginally and was packed with gel-foam and gauze pack. The bleeding continued. She was given 20 cc. of anti-hemophilic globulin, and in five minutes the bleeding stopped. All the while the patient had been receiving whole blood, for a total of seven pints.

Case 6.—Mrs. McK. was aged twenty-one, gravida 4, para 3. Her first two pregnancies were normal; her third pregnancy was a stillborn in 1950, supposedly of toxic separation of the placenta. The present pregnancy was uneventful and the estimated date of confinement was November 15, 1951. On morning of November 17 the patient began to bleed and was admitted to the hospital, with an estimated loss of 200 to 300 cc. of blood. She was having occasional abdominal cramps, but no definite uterine contractions were noted. Her general condition was good; blood pressure 112/68; fetal heart satisfactory. She was still bleeding moderately on admission to hospital at 11:20 a.m. At 12:15 p.m. the patient was given 20 cc. of anti-hemophilic globulin, and at 12:45 p.m. the bleeding stopped. At 2:30 p.m. on November 18 the membranes were ruptured artificially and at 6:37 p.m. she was delivered of a normal infant with no difficulty.

Case 7.—Mrs. A. F., aged twenty-two, had a fairly difficult low forceps delivery after long labor. There was moderate bleeding post-partum, with extension of the

episiotomy along the vault. She was discharged after five days. She returned to the hospital on the seventh day post-partum, with severe bleeding, not from the cervix, but there was severe oozing from the episiotomy wound in the vagina. She was given 20 cc. of anti-hemophilic globulin. The bleeding promptly stopped. She received a transfusion the next day and was discharged in two days with no further bleeding.

Case 8.—Mrs. W., aged forty-three, had moderate uterine bleeding for ten days and severe bleeding for twenty-four hours. Dilatation and curettage were done, but the bleeding continued. The uterus was fibrotic and there was probably one small fibroid in the uterine cavity, felt by the curette. After the dilatation and curettage she was bleeding quite heavily. She was given 20 cc. of anti-hemophilic globulin, and the bleeding promptly stopped. She was discharged forty-eight hours later with no further bleeding.

Case 9.—Mrs. R., gravida 3, had an uneventful prenatal course until she was estimated to be about five months pregnant. Suddenly she began to have painless bleeding. The patient was admitted to the hospital and given sedatives and 10 mg. of stilbestrol three times daily for two days. The bleeding subsided somewhat, but she was still losing some blood and a few blood clots. She was given one unit of anti-hemophilic globulin, and the bleeding promptly stopped. She was discharged in forty-eight hours.

Schneider[2] reports three cases of abruptio placenta, treated by cesarean section. In all three cases the fibrinogen level of the plasma was very low. These levels were taken several hours after the onset of the symptoms. The first patient was also a pre-eclamptic and her level was 0.11 gm. per cent. The second patient had 0.09 gm. per cent, and in the third the level was too low to be read. Normal values for pregnant women at term range from 0.3 to 0.7 gm. per cent, and for pre-eclamptic patients the values range from 0.3 to 0.9 gm. per cent.

In his three cases, fibrinogen levels were back to normal within three days after the abruption. His analysis of the cases indicated that the patients must have had normal fibrinogen levels before the acute onset of the abruptio. All of them developed an acute fibrinopenia, and all rapidly began to form fibrinogen again, since in all of them, fibrinogen was soon restored beyond the level attributable to transfusion. Schneider theorizes that the abruption frees the thromboplastin from the decidual tissue. Thromboplastin then enters the maternal circulation and causes a widely disseminated intravascular deposition of fibrin, thus producing fibrinopenia. The utilization of fibrinogen in this process may deplete this substance so severely that it may become insufficient for hemostasis.

J. Frederick Johnson, Walter H. Seegers, and R. G. Braden[1] have studied the plasma Ac-globulin and fibrinogen levels in two cases of abruptio placenta.

In the first case, one hour after fetal heart was no longer heard, the Ac-globulin was less than ¼ unit per milliliter as compared with normal plasma Ac-globulin of 13 to 17 units. The prothrombin concentration was 40 per cent of normal, and the fibrinogen content was less than 10 per cent of normal. The patient had a stillbirth and was given 500 cc. of blood. Seventeen hours after delivery, the Ac-globulin was only 3 to 5 units per milliliter, but the fibrinogen content had been restored to a greater extent, as had the plasma prothrombin. The Ac-globulin concentration reached normal values two to three days after delivery, thus indicating that this clotting factor is restored slowly.

In giving anti-hemophilic globulin intravenously, we are adding to the blood three factors: fibrinogen, Ac or accelerator globulin, and the anti-hemophilic factor. One vial of the powdered globulin, containing 200 mg. of fibrinogen, is mixed with 20 cc. of distilled water (for convenience in administration), and it is injected quite rapidly. There have been no undesirable reactions noted so far. In one case, 18 units of the globulin were given without any complications.

We are satisfied that anti-hemophilic globulin is a worthwhile product in certain kinds of bleeding. We believe that further studies, both clinical and laboratory, should be carried out in an attempt to still further evaluate this product.

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Why does Government cost more? Here's a clue:

The Declaration of Independence contains 300 words: The Ten Commandments contain 297 words; The Lord's Prayer contains fifty-six words; The two Commandments that comprise the whole law of God contain twenty-three words.

But despite the examples of simplicity and brevity set by these masterpieces of wisdom and literature, the OPS order setting the price of cabbage contains 26,911 words.

Why Michigan's Basic Science Law Should Be Repealed

By Franklin L. Troost, M.D.

Holt, Michigan

BEFORE OPENING this discussion, the writer will give his sources of information for the facts presented in this paper. They are the United States Census Bureau; the Directories of the American Medical Association; the State Board Numbers of the American Medical Association; the Federation Bulletins published by the Federation of State Medical Boards of the United States; Special Bulletin 370 on Distribution of Doctors of Medicine and Osteopaths in Michigan Communities, written by Dr. John F. Thaden of Michigan State College; Michigan Department of Health Office Law Enforcement Reports, and the basic science laws of the eighteen states and the District of Columbia which have such laws. The laws of all of these states have been carefully studied and material from them will be used in this paper. The State of Nevada passed a basic science law in 1951, but there are no figures yet available on its application; therefore Nevada will not be included.

My interest in Michigan's basic science law came about through my term of service for nearly five years, from February, 1947, to November, 1951, as a member of the Michigan State Board of Registration in Medicine. This term brought to me the appalling results of our basic science law in depriving Michigan people of badly needed medical doctors. Further it has crippled all of our large teaching hospitals because interns and residents cannot be secured in sufficient numbers. No one disputes the fact that our state is desperately short of medical care; there is a difference of opinion as to how to correct the situation. An attempt will be made to keep statistics at a minimum; it will, however, be necessary to use a certain amount of them. Let me emphasize that this article is written at my own behest and that the Michigan State Board of Registration in Medicine has nothing to do with it. The board has never taken any action on the basic science law.

EDITOR'S NOTE: The Council, at its January 25 and 26 session, authorized publication of a paper by Dr. Troost and a reply by Dr. Spalding, for general information prior to the Annual Session in September.

Historical

Connecticut was the first state to pass a basic science law. This happened in 1925. In the same decade Arkansas, District of Columbia, Minnesota, Nebraska, Washington and Wisconsin followed suit. In the 1930's, Arizona, Colorado, Florida, Iowa, Michigan, Oklahoma, Oregon and South Dakota passed similar laws. In the 1940's New Mexico, Rhode Island, Tennessee and Texas joined in. In 1951 Nevada also approved like legislation. The avowed purpose as set forth in some of these laws was to protect the health or safety of the citizens of the state and to improve the standard of the *healing arts*. None of them mentions improving the standard of *medical practice*. One can see that the high tide of basic science laws was reached in the 1930's. Since then the enthusiasm for them has waned. In spite of their high-sounding avowed purposes and sanctimonious preambles, these laws were designed to exclude those of other schools of practice, namely, osteopaths and chiropractors. This is a serious statement, but in a matter of this kind, we must be candid. Has this happened in Michigan? We shall see.

Interstate Medical Reciprocity

The following is taken from a paper delivered in 1950 by Jacob L. Lochner, M.D., secretary of the New York State Board of Medical Examiners and president of the Federation of State Medical Boards of the United States:

"The evident original purpose of basic science laws as a prerequisite for licensure in all of the healing arts was to exclude from licensure inadequately trained practitioners. There appears to be considerable doubt as to whether they have or are accomplishing their purpose. Statistics would indicate that the number of cultists examined in 1946 comprise only 3.5 per cent of the total number of 3,333 candidates examined that year. In order to control this 3.5 per cent of applicants for licensure plus 6 per cent of osteopathic candidates, the remaining 90 per cent (all graduates of approved medical schools and many with additional postgraduate training) are required to submit to the basic science board examination. All but four of the basic science boards apparently have the discretionary power to endorse basic science examinations given in other states but apparently many of them are not willing to exercise this power. Therefore, the basic

science boards offer one of the most important obstacles to more widespread interstate endorsement."

Dr. Roy Harrison addressed the annual meeting of the American Association of Basic Science Boards in February, 1948, as follows:

"With the present setup, I am very fearful that such a thing as reciprocity by all states is a very long way off. Louisiana could easily put in a basic science board as a subsidiary to our board but I cannot see any reason for it, and if we would put one in, it would be in a form of subterfuge purely to meet certain technicalities of other states so that our applicants could get repicrocity. I would admit that that may be one way out and several of the states may have to resort to such a plan, but I certainly do not think that it is necessary."

Dr. Harrison was also perturbed at the situation a physician finds himself in who has met all the requirements of the law and who is eligible for reciprocity but cannot get it without taking the basic science examination.

In 1950 Michigan has accomplished interstate medical reciprocity with every state in the Union, except for Florida, which has no reciprocity with any state in either medicine or basic science. No other state in the country has as widespread medical reciprocity as Michigan. In 1951, Massachusetts removed Michigan from the list of states with which it reciprocates. Its reason was that Massachusetts physicians, to practice in Michigan, must first pass our basic science examination, while Michigan physicians, going to Massachusetts, would not be faced with this ordeal. Can we blame Massachusetts? Certainly not. There have been mutterings from other states on this line and our fine interstate reciprocal medical reciprocity is in danger of collapse. Do you doctors want that to occur?

Some twenty-five or more years ago, Dr. F. A. Coller, head of the Department of Surgery at Ann Arbor, and Dr. Cyrus Sturgis, head of the Department of Medicine, came to Michigan from Massacrusetts. If men of that calibre were to come to the University of Michigan or to Wayne University today to accept the chair in some department of our medical schools they would be required to take the basic science examination if they graduated after 1941. Could we expect to get such men into Michigan if they were required to face this examination? The answer, I believe, is very obvious.

Basic Science Reciprocity

There are those who say that we should retain our basic science law because our own basic science licentiates would lose their basic science reciprocity if they moved to other states having basic science laws. Actually Michigan has basic science reciprocity with just three states: Arkansas, Minnesota and Nebraska. In any other basic science state, our doctors would be required to take the basic science examination. Therefore, this argument does not hold much weight.

At the present moment (February, 1952), the Michigan State Medical Society is sponsoring a bill in the legislature of the State of Michigan to amend the basic science law. One provision is to remove the subjects of hygiene and public health from our basic science law. The object is to open up more possible interstate reciprocity in basic science with other basic science states. At present only Michigan and Texas include public health in the basic science subjects, but most of the states require hygiene. The states that do not require hygiene are Colorado, District of Columbia, Florida, New Mexico, Rhode Island, South Dakota, Tennessee and Wisconsin. If we eliminate hygiene, it is very likely that we will lose the three states—Arkansas, Minnesota and Nebraska—with whom we have reciprocity, as they all require hygiene. In their place, we might effect reciprocity with only Colorado, District of Columbia, Rhode Island, South Dakota, Tennessee and Wisconsin. The states of Florida and New Mexico reciprocate in basic science with no other state; this is also true of the states of Connecticut and Washington. At present, Rhode Island reciprocates in basic science only with the Massachusetts Board of Registration in Medicine. Thus, if our law is amended as submitted, we shall have potential reciprocity in basic science with only five or six states, most of them being small states. This writer believes the proposed amendment to be very bad from that standpoint. It will make our reciprocity in basic science smaller rather than larger.

Other Schools of Practice and Our Basic Science Law

The most frequent question asked concerning repeal of our basic science law is: "Would not repeal open the gates to those of other schools of practice?" The gates are wide open now. In 1940 there were 435 osteopaths registered in Mich-

igan; in 1950 this has increased to 907, an increase of over 100 per cent in ten years, *during which time the basic science law was in effect.* Chiropractors registered in Michigan increased from 492 in 1940 to 747 in 1950, an increase of 50 per cent. There are some 11,000 osteopaths in the country. On a population basis, we should have about 4 per cent of them. Actually we have between 8 and 9 per cent, and all this has come about with our basic science law in full effect. Does our law keep them out? Most definitely not. People will ask "How do those of other schools get into the state, then?" A few come in by examination, most of them by reciprocity in basic science with Minnesota, Nebraska and Arkansas—chiefly Minnesota. In 1949, Michigan issued 126 basic science certificates by reciprocity; only 38 of these to medical doctors, the rest being to osteopaths, chiropractors and unclassified. It must be granted that if our law were repealed we would probably have more than ever of the other schools for a short while. Soon, however, our state would secure enough medical doctors and the situation would take care of itself. Many people are cared for by non-medical men because there is no medical care available. This writer has enough confidence and pride in the medical profession to believe that most of the people would come back to us if there were enough of us to serve them.

States without basic science laws are not overloaded with those of other schools. Illinois has 12,795 medical doctors and less than 500 osteopaths. Ohio has 9,883 medical doctors and less than 500 osteopaths. Neither state has a basic science law. When there is enough medical care available, the other types of practitioners fade away to large extent.

Who Favors Repeal of Our Basic Science Law?

Repeal of our law is favored by many of the leading medical educators of this state. These men, in their contact with students and interns, have learned that many of our own graduates and those from other states are not interested in practicing in Michigan because in addition to a state board examination they must face the basic science examination. Among those in favor of repeal are Dr. A. C. Furstenberg, dean of the Medical School of the University of Michigan; Dr. Gordon Scott, dean of Wayne University School of Medicine; Dr. F. A. Coller, professor of surgery at the University of Michigan; Dr. Paul Barker and Dr. H. M. Pollard, both of professorial rank in the Department of Medicine at Ann Arbor; Dr. Clarence Owen, pathologist at Grace Hospital, Detroit, and Dr. Frank Weiser, who has charge of intern and resident training at Grace Hospital. These men have learned in their teaching duties that we cannot interest enough young doctors to take residencies in our great teaching hospitals, as our laws require that residents be licensed, and licensure depends on a basic science certificate before they can be examined or licensed by the State Board of Registration in Medicine.

Both Dr. Furstenberg and Dr. Scott have volunteered to appear before our House of Delegates next fall to plead for repeal of the basic science law.

Some years ago the doctors of Washtenaw county introduced a resolution in the House of Delegates of our State Society to repeal the basic science law. In 1950 and 1951, Ingham County Medical Society instructed its delegates to introduce a similar resolution. The reference committees to which these resolutions were referred in both 1950 and 1951 brought in a favorable report recommending that the law be repealed. The chairman of the 1950 committee was Dr. Frank Weiser, mentioned above; the chairman of the 1951 committee was Dr. Arch Walls of Detroit, recently president of Wayne County Medical Society and a man who holds high office in the American Academy of General Practice. In fact, the Legislative Committee of the State Society in 1950 adopted a resolution recommending repeal of the law, the committee favoring repeal by a vote of 11 to 2. Could you think of a more impressive group than these men mentioned above?

In 1950 the question was put aside by the House of Delegates for another year's study. In 1951 repeal was defeated in the House of Delegates by a narrow margin. Many of those voting against the motion, or who did not vote, told this writer that they wanted to talk it over with their constituents back home before voting for repeal. When the doctors of the state realize what this law has done in depriving our people of medical care, it will be repealed.

Who Favors Retention of Our Basic Science Law?

Many who favor retention are those who do not know the facts as to what has happened to our physician supply since the advent of basic science. It is hoped this article will bring to them

the facts. Others are those who twenty years ago began to sponsor this law and do not like to see their efforts of two decades ago put aside. Basic science laws were the vogue of the 1920 and 1930 eras. Let us be up to date; let us realize that in the present decade there is keen competition for medical doctors and we must do all we can to get our share so that the people of Michigan can be served. Some will say that no state has ever repealed its basic science law. This is true. Michigan State Medical Society is proud of its "Michigan Firsts" in medicine. Let us be the first to rid our state of such legislation and watch the other states follow along.

Some say that it is a good law but that it has been poorly administered. What is good about it? Has it kept out those of other schools of practice? It has not. Has it kept out medical doctors? Very definitely yes. If our law were the most perfect one in the country and if it were administered to perfection, it still would not help us, as the medical students and doctors *would still have to take the examination, and they will not do it in sufficient numbers.*

I have asked proponents of this law to give me one single, solitary, valid reason to keep it. The only reason I can find is that those who fostered it do not care to admit it was a mistake and did not turn out well. Could they not swallow their pride if it would give the people of the state enough doctors to take care of them? If that is the reason, then I say we have failed in our trust—we have failed in our duty to serve the sick to the best of ability, and all because we will not correct a mistake that we made. Can we afford to keep the basic science law with people clamoring (and correctly) that they cannot get doctors. Of course we cannot; we should do all we can to encourage qualified medical doctors to come into Michigan instead of doing all we can to keep them out.

I do not agree with the oriental philosophy of saving face. My philosophy is to save the health and lives of our citizens by making medical care available to them.

The Michigan State Medical Society is sponsoring another amendment to the basic science law. This reads: "That this act (the basic science law) shall not be construed as applying to interns and residents who are training in Michigan hospitals." A companion bill would also exempt interns and residents from being required to obtain a Michigan license. It is admitted that these would solve, to large extent, the problem of the hospitals not having sufficient residents. They always had a plethora of residents before we had basic science. However, it would not give us more practicing doctors, but rather less. These men, judging by past experiences, would put off taking their examinations until they had finished their training. Then they would be ten years away from their bacteriology, chemistry and other subjects and would not take the basic science examination, or, if they did, most of them would fail. Many are licensed in other states before coming to Michigan, or are National Board diplomates, thus giving them plenty of places to locate without further examinations and we would lose them.

Results of Basic Science Examinations in Michigan

The following figures are taken from the *Journal of the AMA* for the last five years in their state board numbers. In 1946, 1947, 1948, 1949 and 1950 a total of 1,979 medical doctors and medical students took the Michigan basic science examinations. Of the 1,979, 452 failed. This is a failure rate of 23 per cent. In other words, the basic science law cost us directly 452 physicians through failure. The national average of failure of medical doctors and medical students on basic science is about 12 per cent. Michigan's failure rate is thus almost double the national average.

It is not only those who fail who concern us. There are many well-trained medical doctors, general practitioners and specialists alike (many of whom have passed the boards in their specialities) who would like to move into Michigan. But we have a most effective road block in their way: the basic science law. If this law were repealed, they could come in through interstate reciprocity from almost any state in the country. How many there are of these is of course impossible to say. The best estimate is that we lose more this way (through their refusal to take the basic science exams) than we do through direct failure.

Just today this writer talked with four interns at the E. W. Sparrow Hospital in Lansing. All of these men are National Board diplomates, and all came from other states. All can be licensed in their own states upon completing their internships. All want to stay in Michigan and practice in small communities. None of them is going to practice in

Michigan as they do not have the time to spend preparing for the basic science examination. This is an example of why we have such a paucity of doctors of medicine.

Let no one think that basic science is popular throughout the country. While nineteen states and the District of Columbia have such laws, many of them are very small states. In 1950 there were 201,277 medical doctors in the country. Only 50,787 of them were located in the basic science states. In other words, when a young doctor wants to locate, there are three places out of four that he can go to without bothering with a basic science examination. No wonder they pass us by.

Michigan's Need of Physicians

The following article was copied from the December, 1951, issue of the *Bulletin of the Wayne County Academy of General Practice:*

"The President's Message in the *Muskegon County Medical Society Bulletin* was very interesting. That county has eighty-two M.D.'s for a population of 112,000 people, but of that total he figures there are only about thirty physicians who are either willing or capable of giving general medical care to the population. In other words there is one general practitioner to 3,733 persons.

When only three out of eight physicians can and will make house calls and attend the average family's emergencies, it is a strained situation. The English panel system limits a physician panel to a top of 4,000 people so each of these thirty in Muskegon must be traveling at high speed and doing a production type of medicine of necessity.

Is it any wonder the so-called cults are doing a thriving business and in many places are replacing the M.D.'s?"

How does this article strike you?

The following statements are taken from Dr. Thaden's article mentioned at the beginning of this paper.

"There is a total of 6,937 physicians in Michigan (1950). This is a ratio of 919 persons per physician. For the United States the ratio is 749 persons per physician."

"From 1910 to 1950, the number of physicians in Michigan increased from 4,100 to 6,937, an increase of 69 per cent, while total population increased 126 per cent."

"From 1910 to 1950, the number of persons per physician increased from 685 to 919."

"Between 1930 and 1950, the number of persons per physician increased from 1,292 to 1,728 in the twenty-two entirely rural counties and from 857 to 903 in the sixty-one counties with both rural and urban populations."

"One-fourth of the communities surveyed are adequately supplied with physicians and three-fourths are not."

Medical Schools in State, 1940-1949, Graduated Less Than Half of State's Requirements

"It seems that the demands for physicians in Michigan have consistently exceeded the supply of medical doctors who have been graduated from the medical schools located in Michigan. The number of persons who were graduated from the University of Michigan Medical School during the decade 1940-1949 totaled 1,189. The corresponding figure for the College of Medicine of Wayne University was 711, a combined total of 1,900, which is a considerable number. Nevertheless, this figure is slightly less than one-half as many persons as were licensed to practice medicine in Michigan by the State Board of Registration in Medicine during that same period—a total of 3,815. One logical deduction is apparent: that the number of graduates from Michigan's two medical schools during the past decade was insufficient to replace the doctors who retired, became inactive, died, or moved to other states and at the same time was inadequate to keep pace with the state's rapidly growing population."

Doctors of Medicine Licensed to Practice in Michigan, 1940-1949, Are Predominantly Natives of Other States and Graduates of Medical Schools Outside of Michigan

"Most of the graduates of medical schools in Michigan, soon after completing one year of internship, apply to the Michigan State Board of Registration in Medicine for approval to practice medicine within the state. As previously mentioned, a tabulation of those approved during the decade 1940-1949 shows that a majority were born in other states (or countries) and are graduates of medical schools outside Michigan. Less than one-third (31 per cent) of the 3,815 medical doctors who were approved were born in Michigan. Less than one-half (44 per cent) were graduated from either of Michigan's two medical schools. In only two years (1943 and 1944) were as many as one-half of those approved to practice medicine in Michigan graduates of the state's own schools of medicine."

It is to be remembered that our 6,937 physicians includes all of those in the state. This includes interns, retired doctors, those in public health work, state hospitals and others. Actually only 5,343 doctors were engaged in private practice in 1950. Just 5,343 men to render medical care to all of the 6,300,000 people of Michigan! In 1940, there was one doctor for every 752 people in the country and one for every 749 in 1950. This stayed practically stationary. In Michigan the number increased from one to every 826 people in 1940 to one to every 919 in 1950. Every year our shortage gets worse. At present we have 20

per cent less doctors than the nation as a whole. Of the doctors in the state, about one half were graduated in our medical schools. We must import the rest of them. The increase in the size of classes in our medical schools will increase our total graduates from seventy-five to ninety per year, nowhere near enough. Reciprocity will not help. As many doctors leave the state by reciprocity each year as come in. In time, this will be more unfavorable as only those who graduated by 1941 can come in by reciprocity without taking basic science examinations.

In the last decade, Michigan's population increased 1,115,660 people, the total number in the state now being 6,371,766. During this same period, the number of physicians in the country increased 26,114. Michigan's increase of physicians numbered only 575. That is only one new medical doctor to about 2,000 new citizens in our state. If we take the national average of one doctor to every 749 people, our physician increase should have been 1,489. Our total population increase in the last ten years was exceeded only by California, Texas and New York. We gained more people than did the states of Ohio, Pennsylvania and Illinois. The census bureau estimates that the population of the country increased by 2,500,000 people in 1951. At one doctor per 749 people (the national average), 3,338 more doctors were needed in the country in 1951 than in 1950 just to take care of this increase of population. This is more than half the number that the medical schools graduated. There will continue to be keen competition for medical doctors. Does it not seem sensible that we revise our thinking to meet present needs and make it possible for Michigan to get its share of doctors by elimination of the deterrent influence, the basic science law?

On a population basis, we should have 8,400 doctors, so at present we are short 1,500 doctors of medicine. We are a progressive, growing state, gaining population at the rate of 110,000 people per year. Doctors would be glad to come to Michigan but will not or cannot because of our basic science law.

In 1950 there were 6,002 new young doctors who took a license for the first time. Of these, only 186 came to Michigan. Ohio, with a population only 25 per cent greater than that of Michigan, secured 348 of these young doctors, almost double of those we secured. New York State, with a population double ours, obtained 701, almost four times as many as we did.

Where are we going to secure the 1,500 doctors that we are now lacking? Where will the replacements come from for the 150 to 200 Michigan doctors who die or retire each year? Where will the 143 (one for every 749 people) doctors come from to serve the annual population increase of 110,000 a year? If we could secure 500 medical replacements a year for a period of ten years, we would finally get up to national physician-population ratio. Of this 500 needed we secured only 186 in 1950. The answer as to where the needed doctors are coming from is that *they are not coming*—not coming until we become realistic and repeal the basic science law.

What to Do

Many doctors ask what they can do to get the basic science law repealed. If this article has convinced them that it should be done, they can ask their fellow practitioners to read it carefully. Then they can bring the matter up in their county medical society meetings and have their delegates instructed to vote for repeal in the House of Delegates in 1952. There are those who will say that it will be difficult to get it through the Legislature. This I do not believe. Everyone admires a man or a group who has made a mistake and is willing to admit it and try to rectify it.

For a period of thirteen or fourteen years this country tried prohibition. It turned out to be a failure and was discarded. The basic science law has been a dismal failure in its fifteen years of existence. Cannot we be honest enough to admit we made a mistake and take the necessary steps to correct it? I think we can.

Let us not temporize with this problem. Amendments to the basic science law cannot solve the problem. Either we have a basic science law or we do not. Let us meet this head on with courage and with faith. Let us repeal the basic science law in its entirety; let us be neither apostles of appeasement nor disciples of despair.

Reply to Article by Dr. Franklin L. Troost on Repeal of Basic Science Law

By Edward D. Spalding, M.D.

Detroit, Michigan

There appears in this issue of THE JOURNAL OF THE MICHIGAN MEDICAL SOCIETY a 4,700 word article by Dr. Franklin L. Troost calling loudly for the repeal of the basic science law of this state. When a resolution from Ingham County to this effect was reported on favorably by a reference committee, the 1950 House of Delegates, instead of passing the resolution, referred the question to a special study committee. This study committee after some months of careful consideration unanimously reported that they considered the law fundamentally to be a good one, but that certain modifications in it should be made. The primary difficulties, they claimed, were not in the basic science law itself, but in its administration on the one hand, and in the medical practice act on the other. *(All this is not mentioned in Dr. Troost's article.)*

The 1951 House of Delegates, on receiving the report of the study committee, and after quite prolonged debate, voted *not* to work for the repeal of the basic science act by the very substantial majority of 71 to 23 (and not the "narrow margin" claimed by Dr. Troost). Instead appropriate efforts were made to effect modifications in the basic science law along the lines suggested by the study committee, and also in its companion bill, the medical practice act. These were successful, and this April the Legislature passed, and the governor signed, the amended basic science act, which has six changes, the most important of which are: (1) elimination of examinations in "hygiene and public health" (to be in conformity with a number of other states); (2) not requiring re-examinations in those subjects previously passed; (3) not construing the act to apply to interns and residents in training in Michigan hospitals; (4) requiring the Board of Examiners to file with the Secretary of State each January a list of all those certified during the preceding year.

The modification of these two acts does away with the basic difficulties previously encountered and leaves the law, with the proper restrictions, to operate as was the intent when originally passed.

The arguments of the essayist about the keen competition among the states for young doctors and that "we must do all we can to get our share" make sorry reading. What we need, and *want,* is young men of ability, not just numbers. Are we to believe that the present generation of young medical men is intellectually so feeble that an examination in the basic sciences represents a formidable obstacle? If so, the country is indeed in bad shape.

A proper modification of a fundamentally good law has been achieved. It should now be permitted to function; and let us hear no more of this casting off of all restrictions, just because in its application some adjustments were found to be necessary.

MSMS

NEURODERMATITIS

(Continued from Page 864)

difference whether the patient is sheltered and well balanced or exposed to evil experiences. His peculiar innate personality, his restlessness, his conditioning to itching and scratching, and his abnormal reaction to frictional trauma are stigmata and not acquired properties.

The disease has characteristic but no specific features. The lack of allergenic specificity is best expressed with the very word "atopic." Lack of specific psychologic features has been pointed out by Becker, and the same conclusion can be drawn from the careful analyses of Klauder and of Lynch.

Summary

All known features of neurodermatitis can be interpreted as being due to an inherited constitutional anomaly involving both the psychic and somatic spheres. The main characteristics of this anomaly are emotional instability, pathologically increased conditioning to itching and scratching, abnormal tissue reactions in response to scratching, which in turn lead to itching hyperexcitability, facilitating the creation of itching-scratching cycles. Emotionaly induced vasodilatation may further aggravate the vicious cycle.

MSMS

Desmoid tumors may develop in any of the striated muscles or their aponeuroses.

* * *

Generally speaking, desmoid tumors are not malignant and, while prone to local recurrence, do not metastasize.

Editorial

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
SHERATON-CADILLAC HOTEL—DETROIT
September 24-25-26, 1952

"We hold these truths to be self-evident; that all men are created equal; that they are endowed by their Creator with certain inalienable rights; that among these are life, liberty, and the pursuit of happiness. That to secure these rights, governments are instituted among men deriving their just powers from the consent of the governed."—DECLARATION OF INDEPENDENCE, July 4, 1776.

DEVIOUS METHOD

THE *Saturday Evening Post* of May 10, 1912, published an advertisement, "Hell's Canyon?" The local Electric Light and Power Company, on the Idaho-Oregon border, wished to build a dam and hydroelectric plant on the Snake River, to cost about $357,000,000. Quote: "But the job is held up. For there are those who want the Federal Government to take over electricity—as well as medicine and other businesses and services. They insist that the government develop the power even though it takes longer and costs many millions more."

This advertisement speaks volumes. It points out a roundabout method of giving the politicians control. When bureaucrats get a foothold in electricity, they have demonstrated their abilities to expand and extend their powers and influences. The Tennessee Valley Authority grew out of a flood control project. No one except the Social Planners expected such growth.

On May 19, 1952, another devious method of infiltration was defeated. The Congress was considering a supposedly inoccuous bill to increase the benefits to old-age retired persons, and certain others, about five dollars a month. No one expected opposition. The bill was prepared in secrecy, approved by the Ways and Means Committee, bypassed the Rules Committee, and was called up under suspension of the rules, with twenty minutes of debate on each side and no amendments possible. Federal Security officials had inserted "sleepers" in the bill (hidden, unless one had at hand the basic law which was being changed by words and phrases) so there would be granted increased power to the FSA Administrator to set up a new social security program and name the persons to make the prescribed examinations.

The Congress was faced with the necessity of passing this Socialized Medicine entering wedge or denying the old-age retired persons a paltry five dollars a month. The measure did not carry. That was not a vote against the old-age benefits, but against Socialized Medicine. Promptly President Truman blasted the American Medical Association as having "waved the big stick" and forced the Congress to do its bidding. He accused the American Medical Association of defeating the benefits due to retired persons.

Again government administrators sought to extend Socialized living by devious methods, by subterfuge and misrepresentation. The bill purported to be a benefit for the old people on inadequate retirement allowances, but actually offered a meagre amount of help. It would, however, have extended the F. S. Administrator's grip on the health needs of the nation.

We have mentioned repeatedly that frontal attack in the field of Socialized Medicine is not being pushed, but bites are attempted here and there. Insidious and devious ways are used to further the grasp of the bureaucrats already in the government and to establish new leads. The objective seems to be to use medicine, if they can, or electricity, education, business—any group available—affording professional planners a permanent place in the government and an opportunity to do what they do so poorly in contrast with the natural excellent and wise leaders in medicine, business or industry.

INCOME TAXES

WE HAVE BEEN informed that the Internal Revenue agents are in certain sections now in the process of going over and searchingly investigating the books of all doctors who have gross incomes of $25,000. That limit includes a great percentage of actively practicing physicians.

The inspectors are interested in automobile ex-

penses, and in case of persons who chiefly practice in hospitals then will allow only enough transportation to get from one hospital to another. Costs of getting to the doctor's place of business are not included and have been more or less taboo for some time.

Claims for deduction of entertainment expenses are being scrutinized very carefully. The account must be in the form of checks or receipts showing the time and place of entertainment, the persons present and evidence that those persons have actually referred patients to the doctor. Otherwise the entertainment is claimed to have been a personal expense. For instance, the department is loathe to admit the legitimacy of a specialist entertaining his professional friends.

The department claims that this form of entertainment is actually advertising, and points to the American Medical Association Code of Ethics as prohibiting all forms of publicity which might be construed as advertising.

Why should the medical profession be selected for this special type of attention? It is not the first time we have been suspect. We have one important suggestion for all members who claim deductions in income tax reports. Have every item written down, covered with receipts or checks if possible.

MEDICAL ETHICS AND ADOPTION

THIS STATEMENT is intended to provoke discussion regarding the correct ethical position of the medical profession toward non-relative adoptions. It is not directed at the evil of the black market in babies, against which Michigan has adequate law. It is concerned with those cases in which doctors advise interested would-be parents of the availability of a particular newly-born or about-to-be-born baby, the adopting parents carrying on from there in accordance with the Adoption Law.

The Michigan law provides that first the couple must file a petition to adopt the particular child. Then after proper study of the home by court personnel and after an order severing maternal rights and making the child a ward of the court, the judge may authorize placement of the child in the adoptive home. Thus legally the judge has complete power to decide what is best for the child, but in practice judges can hardly refuse petitions of prominent families of excellent reputation when the petitions are endorsed by highly respected members of the medical profession. The question, therefore, is whether doctors should refuse to divulge information about babies which may be available for adoption, referring all inquiries to the social agencies licensed or authorized by law to make placements.

The doctors who continue to believe that the furnishing of the information about babies to would-be parents is a proper part of medical practice usually believe in their own ability to "pick" would-be parents, despite the fact that few general practitioners or obstetricians know their patients in the intimate personal manner of the practitioner of two generations ago. The picking is even more subjective when non-patient personal acquaintances of the doctor importune him, since he is subject to the common problem of everyone in being impersonal in evaluating friends. The doctor usually also supports his action by believing he is doing a favor to the mother whose hospital bill has to be paid or to the adopting parents who "need" a child, for personal emotional reasons. But the doctor frequently does the adopting parents a dis-favor. Judges usually insist that this type of adoption petition be granted at once, without a waiting period after placement of the child, since otherwise if the unmarried mother disappears, no one will be responsible for the child if the adopting parents change their minds because of disappointment in the baby as it develops; nor does he do a favor to the mother who, after the stress of pregnancy is over, may, too late, reconsider her decision to place the child. Nor does he have time to make a study of the background of the child to determine if he is likely to fit the new home, an assurance to which the natural mother of the child is entitled.

Much more serious, though, is the fact that the baby's rights are overlooked in doing supposed favors to old or new parents. The baby is the patient when the question is placement—not the parents. Have the best possible parents in the community been selected for this particular child? It is impossible for the doctor to answer "yes" to the question in most cases. Yet proper treatment of the patient requires such an answer. No competent doctor has the time to prepare carefully social histories on 100 or more prospective parents from whom he can pick a couple.

Has the time come to write into our ethical code a prohibition on child placing activity?—Prepared by Child Welfare Committee.

Welcome to Detroit!

Michigan's outstanding medical event of the year —the Michigan State Medical Society Annual Session—will once again attract hundreds of medical practitioners to Detroit this September.

The 87th Annual Session offers three information-packed days to the doctors of medicine who will attend from Michigan and the surrounding states in the midwest. The twenty-four authoritative medical teachers from throughout the United States will discuss the latest advances in the swiftly moving science of medicine, September 24-25-26, 1952, at the Sheraton-Cadillac Hotel, Detroit.

Besides the excellent scientific program, this year's Annual Session also will feature social programs of interest to the visiting doctors and their wives. These social affairs include Officers' Night on Wednesday, September 24, at which time a nationally famous personality will present the annual Biddle Lecture. The following night, Thursday, September 25, the Michigan State Medical Society will be hosts to all registrants and their guests at the State Society Night.

An innovation has been added to the scientific program this year. There will be no luncheon meetings. Instead, a daily Discussion Conference will be held from 12:00 noon to 1:00 p.m. At this daily Discussion Conference all of the day's scientific speakers will appear and participate. These daily meetings offer the visiting practitioners an excellent chance to preview and review the day's scientific events. The twenty-four scientific speakers, all outstanding specialists in their particular fields, include the following:

Gaylord W. Anderson, M.D., Minneapolis, Minn.; Claude S. Beck, M.D., Cleveland, Ohio; John J. Bonica, M.D., Tacoma, Wash.; Spencer Braden, M.D., Cleveland, Ohio; George Crile, Jr., M.D., Cleveland, Ohio; Ormond S. Culp, M.D., Rochester, Minn.; Daniel C. Darrow, M.D., New Haven, Conn.; Edwin J. DcCosta, M.D., Chicago, Ill.; Garfield G. Duncan, M.D., Philadelphia, Pa.; Carl W. Eberbach, M.D., Milwaukee, Wis.; Dwight E. Harken, M.D., Boston, Mass.; Peter C. Kronfeld, M.D., Chicago, Ill:; Milton I. Levine, M.D., New York, N. Y.; Roland P. MacKay, M.D., Chicago, Ill.; Samuel F. Marshall, M.D., Boston, Mass.; Earl R. Miller, M.D., San Francisco, Calif.; Emil Novak, M.D., Baltimore, Md.; Duncan E. Reid, M.D., Boston, Mass.; David A. Rytand, M.D., San Francisco 15, Calif.; Ben H. Senturia, M.D., St. Louis 5, Mo.; Evan W. Thomas, M.D., Albany 7, N. Y.; Philip Thorek, M.D., Chicago, Ill.; Leonard F. Weber, M.D., Chcago, Ill.; Claude E. Welch, M.D., Boston, Mass.

While the doctors of medicine are attending the Annual Session in the Sheraton-Cadillac Hotel their wives and their medical assistants will be holding annual conventions concurrently. The Woman's Auxiliary to the Michigan State Medical Society will meet at the Fort Shelby Hotel, Detroit, September 24-25-26, 1952. The Michigan State Medical Assistants Society will hold its Third Annual Convention on Wednesday and Thursday, September 24 and 25, 1952, at the Tuller Hotel in Detroit.

The technical exhibits will be a highlight of the 87th Annual Convention as in the past. A total of ninety-nine technical exhibitors will display the latest in medical supplies and medical equipment.

All doctors of medicine are cordially invited to take part in this outstanding medical event of the year in Michigan. The 87th Annual Session is a stimulating and beneficial experience for every medical practitioner. It is also a time to renew old acquaintances.

You, as a practicing doctor of medicine, will not want to miss this outstanding event.

Michigan State Medical Society

The 87th Annual Session

SHERATON-CADILLAC HOTEL, DETROIT, MICHIGAN

September 24-25-26, 1952

ANNUAL SESSION INFORMATION

DIRECTORY

Headquarters—Sheraton-Cadillac Hotel, Detroit

Registration—Fifth Floor, Sheraton-Cadillac Hotel

Assemblies—Grand Ballroom (Fourth Floor), Sheraton-Cadillac Hotel

Exhibits—Fourth Floor, Sheraton-Cadillac Hotel

Press Room—Suite 500, Fifth Floor, Sheraton-Cadillac Hotel

Woman's Auxiliary Headquarters—Fort Shelby Hotel, Detroit

Michigan State Medical Assistants Society Headquarters —Tuller Hotel, Detroit

* * *

• **REGISTER**—Fifth Floor, Sheraton-Cadillac Hotel—as soon as you arrive.
Hours: Tuesday, September 23—1:00 p.m. to 5:00 p.m.
Wednesday, September 24—7:30 a.m. to 5:00 p.m.
Thursday, September 25—8:30 a.m. to 5:00 p.m.
Friday, September 26—8:30 a.m. to 3:30 p.m.

* * *

• **NO REGISTRATION FEE FOR MEMBERS OF MSMS AND OTHER STATE MEDICAL ASSOCIATIONS, AMA, AND CANADIAN MEDICAL ASSOCIATION.**
Admission will be by badge only to all Scientific Assemblies, Section Meetings, Discussion Conferences and the Exhibition. Please present your MSMS or other State Medical Association, AMA, or CMA Membership Card to expedite registration.

* * *

• **GUESTS**—Members of any state medical association, AMA, or CMA members from any province of Canada, and physicians of the Army, Navy and U. S. Public Health Service are invited to attend, as guests. No registration fee. Please present credentials at the Registration Desk.
Bona fide doctors of medicine serving as residents, interns, or who are associate or probationary members of Michigan county medical societies, if vouched for by an MSMS Councilor or the president or secretary of the county medical society in whose jurisdiction they practice, will be registered as guests. Please present credentials at the Registration Desk.

• **MICHIGAN DOCTORS OF MEDICINE,** in practice but who are not members of MSMS, if listed in the American Medical Directory, may register as guests upon payment of $25.00. This amount will be credited to them as dues in the Michigan State Medical Society FOR THE BALANCE OF 1952 ONLY, provided they subsequently are accepted as members by the County Medical Society in whose jurisdiction they practice.

* * *

• **DOCTOR,** register Tuesday! Registration of physicians will be held Tuesday afternoon from 1:00 to 5:00 p.m.—as well as on Wednesday, Thursday, Friday, during the 1952 MSMS Annual Session. The Tuesday afternoon registration hours are arranged so that physicians may avoid waiting in line Wednesday morning before the opening Assembly.
We recommend to Detroit physicians—and those who arrive in Detroit on Tuesday—that they register Tuesday, September 23, from 1:00 to 5:00 p.m., Fifth Floor, Sheraton-Cadillac Hotel.

* * *

• **REGISTER AT EVERY BOOTH**—There is something of interest or education in the large exhibit of technical displays. Stop and show your appreciation of the exhibitors' support in helping to make successful the 1952 MSMS Convention.

* * *

• **TELEPHONE SERVICE**—Special lines to handle local and long distance telephone service for registrants at the MSMS meeting will be installed on the Fourth Floor, near Grand Ballroom, Sheraton-Cadillac Hotel. Call WOodward 1-8000.

WEDNESDAY, THURSDAY, FRIDAY

The Exhibit Section of the MSMS Annual Session is as important, interesting and desirable to most doctors of medicine as the papers that are presented in the meeting room.
At the 1952 MSMS Annual Session in Detroit, this Section will feature ninety-nine technical displays.
Doctor, visit the technical exhibit (fourth floor, Sheraton-Cadillac Hotel) to see and hear about something NEW.

• **CHECK ROOM**—Fourth Floor, Sheraton-Cadillac Hotel, near meeting room.

* * *

• **GUEST ESSAYISTS** are very respectfully requested not to change time of their lecture with another speaker without the approval of the Assembly. This request is made in order to avoid confusion and disappointment on the part of some members of the audience.

* * *

• **PUBLIC MEETING**—The evening Assembly of Wednesday, September 24—Officers Night—will be open to the public. Invite your patients and other lay friends to this entertaining meeting, to be held in the Grand Ballroom of the Sheraton-Cadillac Hotel at 8:30 p.m. Program on page 888.

* * *

• **CABARET-STYLE DANCE AND ENTERTAINMENT,** with the compliments of the Michigan State Medical Society, will be held in the Grand Ballroom, Sheraton-Cadillac Hotel, Thursday evening, September 25, at 10:30 p.m. All who register, and their ladies, will receive a card of admission and are cordially invited to attend.

* * *

• **TRANSPORTATION**—The C & O Streamliners afford a convenient means of transportation to the MSMS Annual Session in Detroit for hundreds of physicians in the central and western parts of the State. Order reservations well in advance.

* * *

• **PARKING**—Do not park on Detroit's streets. Inside parking, at a convenient distance from the Sheraton-Cadillac Hotel, is available at the Book Tower Garage, 333 State, the DAC Garage, 1754 Randolph, and the Grand Circus Garage, 1776 Randolph.

* * *

• **THE ANNUAL COMMITTEE ORGANIZATION** luncheon, a meeting of the MSMS committee chairmen appointed by President-Elect R. J. Hubbell, M.D., Kalamazoo, to serve during the year 1952-53, will be held on Thursday, September 25, at 12:15 p.m. in the Founders' Room.

SECTION MEETINGS—on Wednesday-Thursday-Friday, September 24-25-26, immediately following adjournment of the daily Assembly.

WEDNESDAY, SEPTEMBER 24, 5:00 to 6:00 p.m.: The following Sections will meet: Dermatology-Syphilology; Pediatrics; Urology; Gynecology-Obstetrics; Ophthalmology.

THURSDAY, SEPTEMBER 24, 5:00 to 6:00 p.m.: The following Sections will meet: Anesthesia; Surgery; Otolaryngology; Public Health and Preventive Medicine; Gastroenterology and Proctology.

FRIDAY, SEPTEMBER 25, 4:30 to 5:30 p.m.: The following Sections will meet: Radiology; Medicine; General Practice; Nervous and Mental Diseases.

For programs and meeting places, see pages 887, 891 and 893.

THREE DISCUSSION CONFERENCES

These quiz periods will be held Wednesday-Thursday-Friday, September 24-25-26, Grand Ballroom, Sheraton-Cadillac Hotel, 12:00 to 1:00 p.m. with all the guest speakers of the day on the platform.

An opportunity to ask questions concerning the presentations of the guest essayists, or to discuss one of your interesting cases with them, will be provided.

• **POSTGRADUATE CREDITS** are given to every MSMS member who attends the Annual Session.

* * *

• **TECHNICAL EXHIBITS**—Ninety-nine (99) Technical Exhibits will open daily at 8:30 a.m. and close at 5:30 p.m., except on Friday when the break-up is at 3:30 p.m. Frequent intermissions to view the exhibits have been arranged before, during, and after the Assemblies.

* * *

INFORMATION OF PRACTICAL VALUE IN DAILY PRACTICE will be found at the Michigan State Medical Society Annual Session. All subjects on the MSMS Annual Session Program are applicable to clinical medicine. They stress diagnosis and treatment, usable in everyday practice.

• **THE MSMS HOUSE OF DELEGATES** convenes Monday, September 22, at 10:00 a.m., Book-Casino, Sheraton-Cadillac Hotel; it will hold three meetings on Monday, September 22, at 10:00 a.m., 2:15 p.m., and at 8:00 p.m.; also two meetings on Tuesday, September 23, at 10:00 a.m. and at 8:00 p.m.

PRE-REGISTRATION OF DELEGATES WILL BE HELD SUNDAY, SEPTEMBER 21, FROM 8:00 TO 10:00 P.M. PLEASE REGISTER IN ADVANCE AND SPARE YOURSELF STANDING IN LINE MONDAY MORNING.

* * *

• **ARCH WALLS, M.D.,** Detroit, is General Chairman of Arrangements for the 1952 MSMS Annual Session in Detroit.

PAPERS WILL BEGIN AND END ON TIME

Believing there is nothing which makes a scientific meeting more attractive than by-the-clock promptness and regularity, all meetings will open exactly on time, all speakers will be required to begin their papers exactly on time and to close exactly on time in accordance with the schedule in the program. All who attend the meeting, therefore, are requested to assist in attaining this end by noting the schedule carefully and being in attendance accordingly. Any member who arrives five minutes late to hear any particular paper will miss exactly five minutes of that paper!

• MEETINGS OF SPECIAL SOCIETIES, ALUMNI AND AUXILIARY GROUPS

Wednesday, September 24, 1952

1. **The Michigan Branch of the Academy of Pediatrics** will have a dinner and business meeting on Wednesday, September 24, 6:30 p.m., in the English Room, Sheraton-Cadillac Hotel.

2. **The MSMS Section on Ophthalmology and the Detroit Ophthalmological Society** will meet for dinner on Wednesday, September 24, 7:00 p.m., in the Pan American Room, Sheraton-Cadillac Hotel.

3. **The Detroit Branch of American Urological Society** will meet on Wednesday, September 24, as follows: reception beginning at 6:30 p.m. in suite assigned to William Bromme, M.D., Detroit, followed by dinner in suite 500 at 7:30 p.m., Sheraton-Cadillac Hotel.

4. **"Upper Peninsula Day"** on Wednesday, September 24, 1952, Sheraton-Cadillac Hotel, Detroit. This will be a get-together with cocktails and dinner in Parlors G-H-I of the Sheraton-Cadillac Hotel at 6:00 p.m.—no speeches.

Thursday, September 25, 1952

5. **Michigan Allergy Society** will meet on Thursday, September 25, for cocktails at 6:30 p.m., dinner at 7:15 p.m. followed by a meeting at 8:30 p.m. in Parlors G-H-I of the Sheraton-Cadillac Hotel, Detroit. Samuel M. Feinberg, M.D., Chicago, Professor of Medicine and Chairman of Allergy Clinic, Northwestern Medical School, will be the speaker.

6. **The Wayne University Alumni Association will** hold an alumni banquet on Thursday, September 25 in the English Room of the Sheraton-Cadillac Hotel at 6:30 p.m. Alumni, their wives and guests are cordially invited. Tickets will be available at the registration desk. Dean Gordon Scott will give a report for the Medical School to the alumni. The banquet program will be dismissed in time for alumni to attend State Society Night in the Grand Ballroom of the Sheraton-Cadillac Hotel.

   An alumni headquarters will be maintained at the Sheraton-Cadillac hotel during the Annual Session.

7. **The Michigan Regional Committee on Trauman of the American College of Surgeons** will meet on Thursday, September 25, for luncheon, 12:00 noon, Pan American Room, Sheraton-Cadillac Hotel. A meeting will follow the luncheon.

8. **The Michigan Chapter of the American College of Chest Physicians** will hold a dinner on Thursday, September 25, 7:00 p.m., in the Pan American Room, Sheraton-Cadillac Hotel.

9. **The Michigan Pathological Society** will hold a meeting on Thursday, September 25, from 2:00 to 4:30 p.m. in the Michigan Room, Statler Hotel, and a dinner and meeting starting at 6:30 p.m. in the Michigan Room. Elson B. Helwig, M.D., of the Armed Forces Institute will moderate a slide seminar covering some interesting dermatologic lesions.

10. **The Michigan Academy of General Practice Board of Directors** will hold a dinner and meeting on Thursday, September 25, 6:00 p.m. in Parlor F, Sheraton-Cadillac Hotel.

11. **The Michigan Chapter, Arthritis and Rheumatism Foundation** will hold a joint meeting with the Michigan Rheumatism Society on Thursday, September 25, 7:00 p.m. (dinner and meeting) in the Founders' Room, Sheraton-Cadillac Hotel.

Friday, September 26, 1952

12. **The Michigan Society of Neurology and Psychiatry** will meet on Friday, September 26, beginning with reception at 5:30 p.m. and dinner at 7:00 p.m. in the Pan American Room, Sheraton-Cadillac Hotel. A business meeting will follow the dinner.

    All those who attend the Nervous and Mental Diseases Section meeting are invited for cocktails at 5:30 p.m. in the Pan American Room as guests of the Michigan Society of Neurology and Psychiatry. The dinner and business meeting are limited to members only.

Women's Organizations

13. **The Michigan State Medical Assistants Society will** meet September 24-25, 1952, Tuller Hotel Detroit.

Wednesday, September 24

A.M.

9:00 Registration at Tuller Hotel
View Exhibits at Sheraton-Cadillac Hotel

9:30 MSMAS Executive Committee Board Meeting

10:30 "Psychological Aspects of Plastic Surgery"
CLAIRE L. STRAITH, M.D., D.D.S., F.A.C.S.
(Lecture and movie followed by question period)

11:30-M. View Exhibits, Sheraton-Cadillac Hotel

P.M.

12:30 Leaving by Bus *from Tuller Hotel* for:
Parke, Davis & Co., trip through Chloromycetin Plant and Research Laboratory
Return to Tuller Hotel for:

6:00 Cocktail Party and Dinner—Entertainment sponsored by Parke, Davis & Co.

Thursday, September 25

A.M.

9:00 Registration at Tuller Hotel
View Exhibits at Sheraton-Cadillac Hotel

10:00 "Surgical Treatment of Deafness"
ARTHUR E. HAMMOND, M.D.
(Illustrated with motion pictures)

11:30-M. "Lecture and Demonstration of the Maico Trainear"
This equipment is designed for the teaching of the hard of hearing children, particularly those of pre-school age

P.M.

12:30 PRESIDENT'S LUNCHEON-BANQUET
Speaker—MR. HUGH W. BRENNEMAN, Public Relations Counsel of Michigan State Medical Society—"Formula for Freedom"

2:00 Annual Business Meeting and Election of Officers (Non-Members welcome)
Followed by
Social Hour to meet your new officers and greet old friends
"Afterglow"—Courtesy—Drug Industries, U. S. Vitamin Corp., J. F. Hartz Company
Non-members welcome to all activities. Registration fee for non-members, $2.00.

14. **The Women's Auxiliary to the Michigan State Medical Society** will meet as follows:
September 22, 23, 24, 25, 1952
Headquarters, Fort Shelby Hotel, Detroit, Michigan
(Registration from Monday noon through Thursday noon)

MONDAY—September 22

P.M.
6:30 Finance Committee Dinner meeting

TUESDAY—September 23

A.M.
11:00 Busses leave Hotels Fort Shelby and Sheraton-Cadillac for Luncheon at Dearborn Inn, followed by trip through Greenfield Village.

P.M.
6:30 Organization Dinner. Mrs. Walter Stinson and retiring and incoming District Directors.
6:30 Past Presidents' and Secretaries' Dinner

WEDNESDAY—September 24

A.M.
10:00 Annual Session opens with Pre-Convention Board Meeting.
MRS. ROBERT S. BREAKEY, President, presiding
(All Officers, Directors, State Committee Chairmen, 1951-52 and 1952-53 County Presidents and Delegates are expected to attend ALL GENERAL SESSIONS)

P.M.
12:30 Luncheon
1:45 Résumé General Session and Annual Meeting
4:00 Business adjourned until 9:00 A.M., Thursday
5:30 Cocktail party
6:15 Annual Banquet (Dress optional). Husbands are cordially invited. Official representatives of MSMS will be our guests.
Speaker: MRS. RALPH EUSDEN, President Woman's Auxiliary to AMA.
8:30. MSMS Officers' Night. Biddle Lecture, Sheraton-Cadillac Hotel

THURSDAY—September 25

A.M.
9:00 Résumé General Session, including unfinished business of Annual Meeting, Election and Installation of officers, and Post-Convention Board Meeting with Mrs. William Mackersie presiding.

P.M.
12:45 Annual Luncheon, honoring Past Presidents Speaker to be announced.
3:30 Adjournment
10:30 State Society Night. Dance and Floor Show. Sheraton-Cadillac Hotel.

NATIONAL TAX FREEDOM HOLIDAY

The first dollar you could call your own, out of all the money you have earned this year, was in your pay of May 19. Up to that day the average American had been working to pay this year's taxes—local, state and Federal.

Never before have Americans had to work so long to pay their taxes. Out of each hour worked, twenty-three minutes pay is taken by the Government in direct and hidden imposts.

Observance of this first day of the year on which a man can call his earnings his own, a day to be celebrated as "National Tax Freedom Holiday," is advocated by Dallas L. Hostetler, executive director of the Florida State Retailers Association.

Last year even Congress recognized the occasion by adopting a resolution providing that it "be symbolized as a day of relief throughout the land, with such demonstrations as may seem appropriate, including a prayer for deliverance."

Last year, local, state, and Federal taxes took thirty-two cents out of each dollar the average American earned. This year the over-all tax load takes thirty-eight cents. Mussolini took 40 per cent of his people's income. Hitler took 50 per cent. Stalin is taking 70 per cent.

In 1920, Americans began working for themselves on February 26 for the first time that year. By 1940 the date had advanced to March 27. In 1951 the tax freedom holiday was observed on April 28. This year it is pushed up to May 19.

"Whither 1953?"

* * *

The incomes below $2000 in 1939 should be compared with an income of about $4000 in 1949 after allowance is made for the depreciation of the dollar and taxes that the Government has taken.

A family which had a $5000 income in 1939 was probably better off than they would be today with $10,000 when one considers the much larger proportion paid out in taxes today.

* * *

HOTEL RESERVATIONS

MICHIGAN STATE MEDICAL SOCIETY

87th Annual Session

Detroit, September 22 to 26, 1952

The reservation blank below is for your convenience in making your hotel reservations in Detroit. Please send your application to Robert M. Buckley, Sheraton-Cadillac Hotel, Detroit, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

.....

Committee on Hotels,
Michigan State Medical Society
c/o Sheraton-Cadillac Hotel,
Detroit, Michigan

Attention: Robert M. Buckley

Please make hotel reservation (s) as indicated below:

.....Single Room(s)

.....Double Room(s) for.....persons

.....Twin-Bedded Room(s) for.....persons

Arriving September.....hour .....A.M. .....P.M.

Leaving September.....hour .....A.M. .....P.M.

Hotel of First Choice:.....

Second Choice:.....

Names and addresses of all applicants including person making reservation:

Name	Address	City	State
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Date ..... Signature.....

Address ..... City.....

GUEST SPEAKERS

G. W. Anderson, M.D.

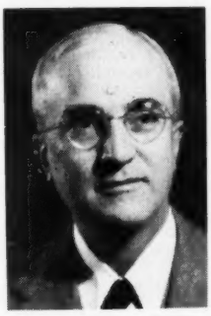
C. S. Beck, M.D.

J. J. Bonica, M.D.

Spencer Braden, M.D.

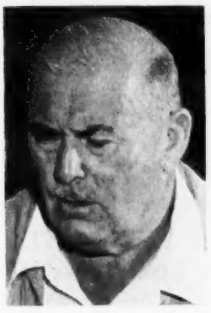
O. S. Culp, M.D.

George Crile, M.D.



D. C. Darrow, M.D.

E. J. De Costa, M.D.



Paul de Kruif, Ph.D.

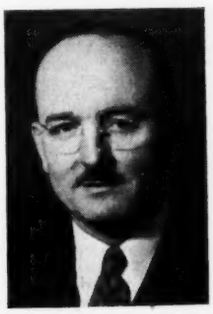
G. G. Duncan, M.D.

C. W. Eberbach, M.D

D. E. Harken, M.D.

P. C. Kronfeld, M.D

M. I. Levine, M.D.



R. P. Mackay, M.D.

S. F. Marshall, M.D

E. R. Miller, M.D.

Emil Novak, M.D.

D. E. Reid, M.D.

D. A. Rytand, M.D.

B. H. Senturia, M.D.

E. W. Thomas, M.D.

Philip Thorek, M.D.

L. F. Weber, M.D.

C. E. Welch, M.D.

Michigan State Medical Society

The 87th Annual Session

PROGRAM OF ASSEMBLIES AND SECTIONS

WEDNESDAY MORNING
September 24, 1952
First Assembly

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: W. D. BARRETT, M.D., Detroit
Secretary: D. R. BOYD, M.D., Muskegon

A.M.

9:00 **"Operation for Coronary Artery Disease"**

CLAUDE S. BECK, M.D., Cleveland, Ohio
Professor of Cardiovascular Surgery, Western Reserve University, Cleveland, Ohio; Associate Surgeon, University Hospitals; Consultant, Crile Veterans Hospital; Visiting Neurosurgeon, Cleveland City Hospital.

The operation is done in two stages. The first stage consists of placing a vein graft between the coronary sinus and the aorta. The coronary sinus is the vein which drains the blood from the heart muscle of the left ventricle. This vein graft establishes an arteriovenous fistula. Three weeks later the fistula is reduced by ligating the coronary sinus where it empties into the right auricle. This builds up a pressure in the venous system of the left ventricle.

This operation protects the heart against coronary artery occlusion. This protection has been well proved by experimental work. It reduces the death rate after an artery has been occluded. It also reduces the amount of destruction in the heart muscle. The mechanism for the benefit has been studied. The operation actually sends blood in a retrograde direction through the capillary bed and it also brings about the development of intercoronary arterial channels.

Sixty-two patients with severe coronary disease have been operated upon. The operation on patients has been shown to be beneficial. Some of the patients received excellent results.

9:30 **"The Overtreatment of Heart Disease"**

DAVID A. RYTAND, M.D., San Francisco, California
Associate Professor of Medicine, Stanford University School of Medicine.

As diagnostic methods increase in number and sensitivity, heart disease is discovered more frequently. Some of this "disease" is nothing but harmless variation from our inadequate conceptions of what is normal. Overtreatment has its roots in overdiagnosis. Accepting an accurate diagnosis of heart disease in a hypothetical patient, one may well remember that the usual aim of treatment is that of such symptomatic management as may prolong useful and comfortable existence. Therapy should be less of a burden than is the disturbance against which it is directed. Unfortunately, however, recent advances in therapeutic agents and concepts have provided increasing numbers of patients whose main complaints are directed justifiably against their treatments rather than against their original disabilities.

It is, of course, the thoughtful physician's responsibility on the one hand to be aware of the potential application of new therapeutic methods to certain of his patients with hypertension, myocardial infarction, angina pectoris, etc., while on the other to avoid excessive or premature enthusiasm in their use. Overtreatment perhaps reaches its peak in ordinary, chronic congestive heart failure. All too often, such patients find themselves on intolerable diets, flat in bed and restricted to use of a bedpan although constipated by inactivity and resins, depleted by diuretics (which are given more often as their effectiveness declines) or by mechanical removal of tissue fluids, receiving anticoagulants for thromboembolism accompanying too-rapid hemoconcentration from mineral and water losses, and intoxicated by long-acting glycosides of digitalis (administered in increasing dosage as tachycardias of toxicity occur). At least some "refractory cardiacs" are best managed by stopping everything but common sense.

10:00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"The Impact of Psychoanalytic Knowledge on the Medical and Surgical Care of Children and Adolescents"**

MILTON I. LEVINE, M.D., New York, New York
Associate Attending Pediatrician, New York Hospital, N. Y. C.; Assistant Professor of Pediatrics, Cornell University Medical College; Consulting Pediatrician, N. Y. C. Department of Health.

Within the past twenty years a great deal of knowledge concerning the developmental needs of children has been accumulated through psychoanalytic observations. This knowledge enters into and affects almost all situations in the medical and surgical care of children. Already certain changes have been made in the approach to infant feeding, in our handling of hospitalization, in our attitude toward masturbation. But there are many situations in the general handling of the child by the physician, in the methods used in diagnosis as well as treatment, in the surgical approach—preoperative as well as postoperative, and in the handling of adolescents where recognition of the emotional needs of the child is invaluable. The use of this accumulated psychoanalytic knowledge differentiates the modern physician from the physician of yesterday.

The paper includes a discussion of such topics as the causes and treatment of constipation, enuresis and feeding problems, indications for hospitalization, the manner of hospitalization, the management of adolescent medical problems, the optional time for elective operative procedures, and the preoperative and postoperative care of the child, all viewed in the light of this new knowledge.

11:30 **"Contact Dermatitis"**

LEONARD F. WEBER, M.D., Chicago
Clinical Professor of Dermatology, University of Illinois College of Medicine.

Contact dermatitis is a disease caused by the local action of irritant substances. Synonyms for contact dermatitis are dermatitis venenata and at times occupational dermatitis. This disease is one of the common diseases of the skin seen in general practice.

The search for and removal of possible cutaneous irritants is of most importance to the patient if his suffering is to be relieved within a reasonable period.

The first sign of inflammation in the skin is redness, and this is followed by vesiculation, oozing, crusting and swelling. Widespread toxic eruptions of eczematoid type may follow as a result of absorption of toxic substances from the original sites of dermatitis. Chronic cases due to prolonged contact with a low sensitizer cause thickening, lichenification and fissures. Secondary infection may be superimposed on the acute and chronic types.

Dermatitis venenata occurs usually on the exposed parts, that is the hands, face and neck. The primary site of involvement often is a clue to the causal irritant. If the cause is obvious and is removed at once, the course of the disease is self-limited. If the offending irritant is again contacted a recurrence will follow.

12:00 **END OF FIRST ASSEMBLY**

WEDNESDAY NOON

(No Luncheons)

September 24, 1952

12:00 to 1:00 p.m.

DISCUSSION CONFERENCE

Grand Ballroom, Sheraton-Cadillac Hotel

Leader: L. J. HIRSCHMAN, M.D., Traverse City
Participants: CLAUDE S. BECK, M.D., Cleveland, Ohio; SPENCER BRADEN, M.D., Cleveland, Ohio; ORMOND S. CULP, M.D., Rochester, Minnesota; PETER C. KRONFELD, M.D., Chicago, Illinois; MILTON I. LEVINE, M.D., New York, New York; DAVID A. RYTAND, M.D., San Francisco, California; and LEONARD F. WEBER, M.D., Chicago, Illinois.

WEDNESDAY AFTERNOON

September 24, 1952

Second Assembly

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: B. M. HARRIS, M.D., Ypsilanti
Secretary: J. G. MOLNER, M.D., Detroit

P.M.

2:00 **"Palpable Masses in the Flank"**

ORMOND S. CULP, M.D., Rochester, Minnesota
Consultant in Urology, Mayo Clinic; Associate Professor of Urology, Mayo Foundation, University of Minnesota.

A discussion of lesions which present themselves as tumors in the upper abdomen, with or without urinary symptoms. To be illustrated by typical cases, with special emphasis on clues which should expedite preoperative diagnosis by the general practitioner.

2:30 **"Bleeding in the Last Trimester of Pregnancy"**

DUNCAN E. REID, M.D., Boston, Massachusetts
Wm. Lambert Richardson Professor of Obstetrics, Harvard Medical School; Chief of Staff, Boston Lying-In Hospital.

In recent years the policies governing the management of obstetrical bleeding in the las trimester have become fairly well standardized. Exceptions are evident, however, and the controversies which revolve about them are of more than academic interest. With respect to placenta previa, considerable wave of enthusiasm has been expressed for a non-intervention form of treatment. The merits and dangers of such a policy deserve careful evaluation. It is generally accepted that the method of treatment to be employed in placenta previa is dependent upon the degree of placenta which is involved in the previa. However, a lack of uniformity in classification lends confusion to the degree of previa present and prevents a careful analysis of results obtained by the various methods of treatment.

Regarding premature separation, an attempt will be made to correlate the clinical findings with the degree of placental detachment. The two more serious complications, namely, anuria and hemorrhagic diathesis will be elaborated upon. A summation of the obstetrical management of these various complications will be outlined and a policy propounded for the treatment of the various forms of premature separation.

3:00 **INTERMISSION TO VIEW EXHIBITS**

4:00 **"The Acutely Inflamed Eye"**

PETER C. KRONFELD, M.D., Chicago, Illinois
Professor of Ophthalmology, University of Illinois

4:30 **"Subarachnoid Hemorrhage with Special Emphasis on Its Management"**

SPENCER BRADEN, M.D., Cleveland, Ohio
Visiting Neurosurgeon St. Luke's Hospital, St. Vincent's Charity Hospital and Huron Road Hospital; Consulting Neurosurgeon U.S.P.H.S. Hospital, Lutheran Hospital and Deaconess Hospital.

5:00 **END OF SECOND ASSEMBLY**

—Program of Sections—

WEDNESDAY

September 24, 1952

5:00 to 6:00 P.M.

SECTION ON DERMATOLOGY AND SYPHILOLOGY

Parlors G-H-I, Sheraton-Cadillac Hotel, Detroit

Chairman: J. R. DELANEY, M.D., Detroit
Secretary: C. J. COURVILLE, M.D., Detroit

"Cutaneous Cancer in Industry"

LEONARD F. WEBER, M.D., Chicago, Illinois

Are occupational cancers uncommon in the United States? Are they increasing because our industry is becoming more diverse? Even when there is known exposure to industrial carcinogens with the appearance of cutaneous cancer later there is considerable difficulty in establishing a causal relationship of this hazard to cancer. Much reliance is placed upon a complete and adequate history to confirm our opinion that cancer may arise out of the occupation. Assume that the history is inadequate or incorrect, then what other criteria do we have which are helpful? None of the known industrial carcinogens cause a type of cutaneous cancer that is readily recognized as a definite histologic structure. For instance, basal cell epithelioma caused by irradiation has the same clinical and histologic appearance as a basal cell epithelioma occurring in a pitch and tar worker.

Of what importance is sex and age in occupational cancers of the skin? Is the occurrence or development of several cancers frequent in occupational malignancy? What part does single or repeated trauma play in the cause of cancer? Occupational and industrial cancer is a medical problem that has many interesting phases. One important part of occupational cancers is that the laws pertaining to some of these cases have limitations as to the time of filing compensation claims.

SECTION ON PEDIATRICS

English Room, Sheraton-Cadillac Hotel, Detroit

Chairman: H. L. FRENCH, M.D., Lansing
Secretary: P. S. BRADSHAW, M.D., Muskegon

"Newer Concepts Concerning Tuberculosis During Childhood"

MILTON I. LEVINE, M.D., New York, New York

The use of streptomycin, PAS, promizale and more recently isonicotinic acid hydrazide has greatly changed our approach to the problem of tuberculosis in children. Should children with uncomplicated primary tuberculosis receive drug therapy or should it be withheld for use in case of hemotogenous spread or the development of a progressive primary process? What are the most recent developments in the treatment of tuberculosis meningitis? Is the use of tuberculin, streptokinase and streptodornase advisable in tuberculosis meningitis?

Other subjects to be discussed are the contagiousness of primary tuberculosis and the question as to whether bedrest or hospitalization is indicated. These problems assume considerable importance for many hospitals refuse cases of primary tuberculosis since they feel that isolation with all the accompanying precautionary measures must be instituted. Furthermore, the question arises as to whether children with active primary lesions may attend school and mingle freely with non-infected children. Some of the more recent thoughts concerning the use of BCG as a phophylaxis against tuberculosis will also be discussed.

SECTION ON UROLOGY

Founders Room, Sheraton-Cadillac Hotel, Detroit

Chairman: R. A. BURHANS, M.D., Lansing
Secretary: WILLIAM BROMME, M.D., Detroit

"Urologic Enigmas"

ORMOND S. CULP, M.D., Rochester, Minnesota

A presentation of "problem cases" which have required unconventional therapeutic measures or have been characterized by bizarre complications.

SECTION ON GYNECOLOGY AND OBSTETRICS

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: L. C. BOSCH, M.D., Grand Rapids
Secretary: J. P. OTTAWAY, M.D., Detroit

"Heart Disease in Pregnancy"

DUNCAN E. REID, M.D., Boston, Massachusetts

While advances have been made in the care of the pregnant cardiac patient, opinion still differs as to which patients with heart disease have the right to accept the risk of pregnancy. The competence of the cardiac patient to withstand pregnancy is dependent upon factors other than her ability to perform satisfactorily her daily activities. These additional data which are required in classifying cardiac patients into "favorable" and "unfavorable" groups with respect to their anticipated response to pregnancy will be discussed.

Moreover, during recent years, the introduction of chemotherapy and antibiotic drugs and the expanding indications for cardiac surgery have created new and interesting problems regarding heart disease in pregnancy. These therapeutic aids have enabled some patients with heart disease to embark on a pregnancy which several years ago would have been regarded as folly. More specifically these include patients with marked pulmonary hypertension resulting from severe mitral stenosis and those forms of congenital heart disease which are amenable to cardiac surgery. These and other major complications will be considered, while the causes of death in cardiac patients will be analyzed and recommendations made as to ways and means of further reducing the maternal mortality.

SECTION ON OPHTHALMOLOGY

Chairman: L. E. MCCULLOUGH, M.D., Detroit
Secretary: L. L. LODER, M.D., Muskegon

The MSMS Section on Ophthalmology will meet jointly with the Detroit Ophthalmology Society for dinner at 7:00 p.m. in *Pan American Room,* Sheraton-Cadillac Hotel.

"Tonography"

PETER C. KRONFELD, M.D., Chicago, Illinois

WEDNESDAY EVENING
September 24, 1952

GENERAL (PUBLIC) MEETING

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

President: OTTO O. BECK, M.D., Birmingham
Secretary: L. FERNALD FOSTER, M.D., Bay City

P.M.

8:30 OFFICERS' NIGHT—PUBLIC MEETING

1. **Call to order, announcements and reports of the House of Delegates by L. Fernald Foster, M.D.**
2. **Introduction of President Otto O. Beck, M.D., followed by President's Annual Address.**
3. **Induction of members into the MSMS "Fifty-Year Club" by President Otto O. Beck, M.D.**
4. **Presentation of Scrolls.**
5. **Introduction of President Elect R. J. Hubbell, M.D., Kalamazoo, and induction of Dr. Hubbell into office of President of the Michigan State Medical Society by the Retiring President.**
   Response of Dr. Hubbell.
6. **Introduction of the new President Elect and other newly elected Officers and of the Chairman of The Council, William Bromme, M.D., Detroit.**
7. **Presentation of scroll and Past President's Key to Retiring President Dr. Beck by the Chairman of The Council, Dr. Bromme.**

9:15 8. **The Andrew P. Biddle Lecture.**
Paul de Kruif, Ph.D., Holland, Michigan
(30 minutes)

Andrew P. Biddle, M.D.
(Deceased August 2, 1944)
Patron of Postgraduate
Medical Education

9. **Presentation of Biddle Lecture Scroll.**

10:00 10. **Adjournment.**

THURSDAY MORNING

September 25, 1952

Third Assembly

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: A. H. MILLER, M.D., Gladstone
Secretary: R. L. FITTS, M.D., Grand Rapids.

A.M.

9:00 **"Pelvic Endometriosis"**

EMIL NOVAK, M.D., Baltimore, Maryland

Assistant Professor Emeritus, Johns Hopkins Medical School; Gynecologist-in-Chief, Bon Secours and St. Agnes Hospitals.

Historical review of subject, and a discussion of chief viewpoints as the etiology of endometriosis, the present trend being that mechanism of its origin is not always the same. Pathologic picture shows many variations in degree, especially in ovary, most common site of endometriosis, though many other possible sites are also discussed. Ectopic endometrium often of immature type, responsive to estrogen but not to progesterone. A brief comment on possible origin of certain ovarian carcinomas from endometriosis of ovary.

Clinical symptoms vary widely in character and degree, and may be absent in some cases. Between cases of only academic and scientific interest and those with severe and at times disabling nature all gradations are encountered. Diagnosis should, with rare exceptions, be based on palpatory findings rather than clinical symptoms, though not infrequently it is presumptive rather than precise. The bearing of endometriosis on fertility is considered a relatively high degree of relative infertility being generally accepted.

The management of endometriosis does not always include surgery, though frequently it does. The scope of operation must be adapted to the extent of the disease, the age of the patient, and the importance or unimportance of further reproductiveness. The increasingly conservative trend in the surgical treatment of endometriosis in the younger group of patients is fully justified by reported results in relief of symptoms and in high incidence of later pregnancy. When dysmenorrhea has been a prominent symptom presacral neurectomy may be advantageously combined with conservative operations. When disease is very extensive, with perhaps serious involvement of bowel, radical operation, with complete removal of ovarian tissue, is fully justified and desirable.

9:30 **"The Adenoid Problem"**

BEN H. SENTURIA, M.D., St. Louis, Missouri

Assistant Professor of Clinical Otolaryngology, Washington University Medical School.

10.00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"Management of Pain of Malignancy"**

JOHN J. BONICA, M.D., Tacoma, Washington

Director, Department Anesthesia, Tacoma General Hospital; Director, Department of Anesthesia, Pierce County Hospital; Senior Consultant in Anesthesiology, Madigan Army Hospital; Senior Consultant in Anesthesiology, Veterans Administration Hospital.

The management of pain associated with inoperable cancer is a difficult clinical problem which should interest every physician. This pain, which in the terminal stages of the disease, is often so intense and persistent as to cause a physiologic and psychologic deterioration. deserves an intelligent appraisal and perhaps equally vital, a systematic plan for relief which will conserve the patients's physical, mental, and moral resources and his social usefulness insofar as possible.

At the present time the management of this problem resolves itself in about four months of approach. The first approach is removal of the cause by palliative operation, radiation therapy, the administration of endocrine substances, castration and other methods which decrease or completely remove the tumor. Unfortunately, these methods all too often are either not feasible or ineffective and, therefore, pain must be controlled by decreasing or preventing its perception and/or by modifying the reaction to it. The value of opiates and other narcotic analgesics in the management of cancer pain is generally appreciated and, therefore, needs no elaboration. It should be pointed out, however, that not infrequently these drugs are misused and even when they are properly administered, they produce certain undesirable effects which aggravate the inanition and cachexia of the patient. Neurosurgical operations designed to interrupt the pain pathways such as rhizotomy, sympathetectomy, chordotomy, and medullary tractotomy or operations designed to modify the reaction to the pain, such as prefrontal lobotomy, when skillfully carried out produce excellent results. However, these procedures impose the risk of major surgical operations and often cannot be tolerated by these patients. Moreover, not infrequently they are accompanied by serious complications.

Another approach to the problem is to chemically interrupt pain pathways by means of nerve blocks. While this method has limitations, it does offer certain advantages which may not be had with any other form of treatment. Effective nerve blocks not only afford relief from pain but may enable the sufferer to receive more intensive radiation therapy and other medical treatment, which otherwise could not be tolerated. Properly executed blocks do not add to the patient's discomfort nor are they often followed by serious untoward reactions such as a severe depression of function inherent to massive narcotic therapy or the mutilation sometimes produced by neurosurgical operations.

In order to obtain optimal results with nerve blocks, the mechanism producing the pain and the pathways over which it is carried must be thoroughly understood and the best agents and technics of producing prolonged interruption must be carefully considered. For pain of the face, mouth, tongue, throat, and neck, alcoholic injections of the trigeminal, glossopharyngeal and/or the upper cervical spinal nerves are usually very effective. Pain below the neck can be effectively controlled for weeks and months with subarachnoid alcohol blocks or injections of peripheral nerves. Since in many of these cases the sympathetic nervous system is involved in the pain mechansims, sympathetic nerve blocks are necessary to completely alleviate the pain. It is necessary for the physician to be always cognizant of the possible complications which can occur with these procedures and special efforts should be made to prevent them. When they do occur they should be properly treated.

The essayist will discuss cancer pain of various regions of the body, the mechanisms producing it and the analgesic agents and technics which produce optimal results. The advantages, disadvantages and complications of each procedure will be stressed.

11:30 **"What Is the Scope of Public Health"**

GAYLORD W. ANDERSON, M.D., Minneapolis, Minnesota

Mayo Professor and Director, School of Public Health, University of Minnesota; President, American Public Health Association.

The fundamental legal mandate given to health departments is that they shall concern themselves "with the interests of health and life among the people." The evolution of public health is a fulfillment of this mandate. Problems have changed from those of environmental sanitation to communicable disease control, then to child health and now to adult health. Throughout its evolution there has been no change in the fundamental concepts of public health but merely in the types of problems against which the people are taking action through their health agencies.

12:00 **END OF THIRD ASSEMBLY**

THURSDAY NOON

(No Luncheons)

September 25, 1952

12:00 to 1:00 p.m.

DISCUSSION CONFERENCE

Grand Ballroom, Sheraton-Cadillac Hotel

Leader: CHARLES S. STEVENSON, M.D., Detroit
Participants: GAYLORD W. ANDERSON, M.D., Minneapolis, Minnesota; JOHN J. BONICA, M.D., Tacoma, Washington; GEORGE CRILE, JR., M.D., Cleveland, Ohio; EDWIN J. DECOSTA, M.D., Chicago, Illinois; CARL W. EBERBACH, Milwaukee, Wisconsin; SAMUEL F. MARSHALL, M.D., Boston, Massachusetts; EMIL NOVAK, M.D., Baltimore, Maryland; and BEN H. SENTURIA, M.D., St. Louis, Missouri.

THURSDAY AFTERNOON

September 25, 1952

Fourth Assembly

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: W. S. JONES, M.D., Menominee
Secretary: P. S. BRADSHAW, M.D., Muskegon

P.M.

2:00 **"Tumors of the Stomach"**

SAMUEL F. MARSHALL, M.D., Boston, Massachusetts

Department of Surgery, The Lahey Clinic.

The early recognition of tumors of the stomach is of paramount importance because approximately 95 per cent of gastric tumors are carcinomas and because the five-year survival rate following operation for carcinoma of the stomach is lower than for any form of malignant disease.

The other tumors of the stomach, which comprise about 1.5 per cent of all such tumors, are the benign tumors, such as adenomatous polyps, fibromas, leiomyomas, neuromas, and so forth. They are of great significance, however, because the adenomatous polyps apparently have a tendency to degenerate into malignant tumors and should be treated as potential malignant lesions. Another group of tumors consists of the sarcomas, the most common of which arise from the smooth muscle and from lymphoid tissue; this group of tumors comprise about 3.0 per cent of gastric neoplasms. Although sarcomas arising from lymphoid tissue are similar to carcinomas, the survival rate is somewhat higher. If sarcomas are recognized early, the opportunity for cure is greater than for carcinoma of the stomach.

In reviewing approximately 1600 or 1700 cases of carcinoma of the stomach, one of the most striking features is the lateness with which the diagnosis is made in most of these cases. Unfortunately, a large percentage of these patients are treatted for months, without roentgenologic examination and without the question of carcinoma of the stomach being raised and thus valuable time is lost before these patients are brought to surgery. Another feature is the tendency of carcinoma of the stomach not only to spread into the lymph nodes but also to show evidence of vascular invasion, diffuse lymphatic spread, and extension to the duodenum. Thus, the decision as to the extent of the resection of the stomach cannot be based entirely upon the gross appearance of the tumor because the tumor may extend beyond the point of transection. This extension can be determined only by study of numerous frozen sections of the duodenal wall or of the gastric wall at the point where the duodenum or the stomach is divided. Because of the difficulty in determining the extent of the tumor, it has been proposed that a more radical operative procedure should be carried out, and there is a growing tendency to utilize total gastrectomy for earlier cases of cancer of the stomach. Over the last three years the mortality has been approximately 5 per cent for partial gastrectomy and 8 to 9 per cent for total gastrectomy. Thus, total gastrectomy is a reasonable procedure to employ in properly selected cases of carcinoma of the stomach.

At this clinic, the five-year survival rate following partial gastrectomy has been approximately 27 per cent, whereas the five-year survival rate following total gastrectomy has been 12.5 per cent. It must be remembered, however, that total gastrectomy heretofore has been employed only for advanced cases of carcinoma of the stomach and the five-year survival rate is limited because this procedure has been used only in this type of case. Whether a higher curability rate will be obtained when a radical procedure is employed can be determined only after careful follow-up studies of the results of total gastrectomy have been made.

One of the most important features in the early diagnosis of gastric neoplasm is the awareness on the part of the physician of the frequency of occurrence of this serious condition after the age of 45 particularly in men. The mere suspicion of a possible gastric neoplasm makes it imperative to carry out accurate diagnostic studies so that these cases are discovered at an early stage of the disease and better results will follow partial gastrectomy or even total gastrectomy.

2:30 **"The Treatment of Chronic Ulcerative Colitis"**

GEOERGE CRILE, JR., M.D., Cleveland, Ohio

Department of Surgery, Cleveland Clinic.

Indications for subtotal colectomy with simultaneous ileostomy in chronic ulcerative colitis are:

1. In patients with long continued activity of the ulcerative process or with pseudopolypoid change, the colon should be removed to prevent the development of cancer. In such cases the risk of colectomy is much less than that of cancer.
2. In patients with systemic manifestations of the disease such as arthritis or pyoderma gangrenosum, the colon should be removed promptly before irreversible damage is done or before the patient's general condition becomes so poor that life is endangered.
3. In acute toxic ulcerative colitis the colon should be removed as soon as possible because the risk of the disease is high and colectomy is the most effective means of preventing its fatal complications. In any case of acute toxic ulcerative colitis in which the colon is distended perforation is impending and a fatal termination is apt to ensue if an emergency colectomy is not performed.
4. Although medical treatment and a trial on steroid therapy may have its place in the treatment of many of the mild or chronic manifestations of the disease, acute toxic ulcerative colitis with distention of the colon is a surgical emergency and should be treated by immediate colectomy.

3:00 **INTERMISSION TO VIEW EXHIBITS**

4:00 **"Cortisone and Pregnancy"**

EDWIN J. DECOSTA, M.D., Chicago, Illinois

Assistant Professor of Obstetrics and Gynecology, Northwestern University Medical School; Associate Attending Gynecologist and Obstetrician, Michael Reese Hospital.

Since the introduction of cortisone (11 dehydro 17 hydroxy corticosterone) in 1949 for the treatment of rheumatoid arthritis, hope has never waned that the "miracle drug" would "cure" just about everything. This miracle drug is actually a hormone. It is one of several hormones which have been isolated from the adrenal cortex. These steroids differ quantitatively from each other in their physiological effects. Cortisone predominantly affects carbohydrate and protein metabolism. In addition it profoundly affects mesenchymal tissue and appears to modify the response of the host to stress. Since pregnancy is associated with tremendous metabolic changes, it is reasonable to speculate that the adrenal hormones may be intimately associated with such changes.

Before using any new substance, one should be able to answer two questions: (1) Is the administration of the substance harmful to the recipient, and (2) Is there any benefit to be gained by using this substance, even if harmless? In applying this generalization to the use of cortisone in pregnancy, one must know whether cortisone is harmful to either the mother or fetus, and whether it is of any value. Surprisingly, to date there is little information to answer either question. In spite of this, cortisone has been used in pregnant women in the treatment of conditions which may or may not be related to the pregnancy.

It is the purpose of this presentation to evaluate the effects of cortisone on gestation, both in the experimental animal and the human, and to consider the clinical application of cortisone during pregnancy.

4:30 **"Hyperthyroidism—Rationale of Modern Treatment"**

CARL W. EBERBACH, M.D., Milwaukee, Wisconsin

Professor of Surgery, Marquette University Medical School.

Since the important contributions to the treatment of hyperthyroidism in 1923 by Plummer, the management of toxic goiter has followed, until recently, rather clearly defined procedures. The accepted and highly successful therapy consisted in iodinization of the patient, and subtotal resection of the thyroid gland. With the introduction of the anti-thyroid substances by Astwood nine years ago, and radioactive iodine isotopes by Hirst, Roberts and Evans in 1938, interest in the etiology of hyperthyroidism and its treatment has been revived and greatly stimulated. In addition to their therapeutic value, the isotopes have opened the vast field of thyroid physiology for study through a new approach.

With three available methods of treatment for thyroid disease, all of which are now well established as sound and effective procedures, it seems wise to look into their mode of attack in order that the proper procedure may be intelligently selected in a given case.

A discussion of these methods in relation to their ef-

5:00

fect on thyroid physiology and pathology will be presented.

5:00 END OF FOURTH ASSEMBLY

—Program of Sections—

THURSDAY

September 25, 1952

5:00 to 6:00 p.m.

SECTION ON ANESTHESIA

Parlors G-H-I, Sheraton-Cadillac Hotel, Detroit

Chairman: A. B. STEARNS, M.D., Detroit

"The Clinical Value of Segmental Peridural Block"

JOHN J. BONICA, M.D., Tacoma, Washington

The many advantages of properly administered and completely effective regional analgesia are recognized and well appreciated by surgeons and anesthesiologists who have had sufficient experience with it. The outstanding benefits are the slight degree of disturbance of physiologic function of the patient and the optimal operating condition which it affords the surgeon. Unfortunately the ever-increasing tendency in America to employ thiopental, curare and other deceptively innocuous general anesthetic agents and muscle relaxants for all surgical operations has caused many anesthesiologists to become nonproficient with regional analgesia. The well-rounded anesthesiologist should be able to administer regional analgesia as well as general anesthesia, not only because of the value of the former in surgery, but also because he is being called more and more to execute nerve blocks for the management of pain in patients with nonsurgical diseases.

Among the many regional anesthetic technics none is more clinically useful than segmental peridural (epidural, extradural) block. This procedure, accomplished by injecting a local anesthetic solution into the space between the dura and periosteum of the spinal canal in a manner similar to spinal anesthesia, can be used to anesthetize any region of the body. After a little experience with it, it can be done as easily and as quickly as subarachnoid block. Moreover, by inserting a polyethylene tube or ureteral catheter in the same manner as continuous spinal, prolonged blocking can be produced and by varying the volume of the solution, the speed of injection and the position of the patient, any number of segments can be blocked. Thus, injection of 10 cc. of local anesthetic solution through a needle inserted in the seventh thoracic interspace produces analgesia involving approximately the fourth through the eleventh thoracic segment. Moreover, by varying the concentration of the solution, the intensity of anesthesia may be varied and muscular relaxation may or may not be produced.

Segmental peridural block affords the same advantages as spinal anesthesia without its disadvantages ,dangers and complications. Since the dura is not pierced, no headaches occur and there is no danger of inadvertently producing total anesthesia and of involving the medullary centers or of producing neurological sequale. Moreover, because in most instances it is not necessary to involve the sacral segments, post-anesthetic difficulty with bladder and rectal function do not occur and there is not the increased tendency for thrombus formation consequent to the inactivity of the lower extremities associated with spinal anesthesia.

Segmental peridural block can be used for intrathoracic, biliary, gastric, and intestinal surgery, for surgery of the chest and abdominal wall, for lumbar-renal and inguinal operations, to control labor pains, for caesarean sections and in neurosurgical procedures involving the spinal column. It is particularly advantageous in the management of pain syndromes involving the trunk and lower extremities.

The essayist will discuss a simple technic of segmental peridural block together with the indications, contraindications, advantages, disadvantages and the possible complications which can occur with this method. A clinical evaluation of the method based on over 1000 surgical and several hundred non-surgical cases will be given.

SECTION ON SURGERY

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: F. P. HUSTED, M.D., Bay City
Secretary: J. M. WELLMAN, M.D. Lansing

"Cancer of the Breast"

CARL W. EBERBACH, M.D., Milwaukee, Wisconsin

SECTION ON OTOLARYNGOLOGY

English Room, Sheraton-Cadillac Hotel, Detroit

Chairman: C. G. WENCKE, M.D., Battle Creek
Secretary: F. A. LAMBERSON, M.D., Detroit

"External Otitis"

BEN H. SENTURIA, M.D., St. Louis, Missouri

SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE

Pan American Room, Sheraton-Cadillac Hotel, Detroit

Chairman: M. R. FRENCH, M.D., Coldwater
Secretary: P. S. BRADSHAW, M.D., Muskegon

"Poliomyelitis Following Injection"

GAYLORD W. ANDERSON, M.D., Minneapolis, Minnesota

This is a critical review of the reports on poliomyelitis occurring subsequent to injection of antigens or other substances. Some previously unpublished data are also presented. The review leads to the conclusion that if an individual contracts poliomyelitis within a month after antigen injection there is a localization of the paralysis in the injected extremity and some tendency toward greater severity of involvement. Evidence for a similar relationship to injections more than a month before onset and to injection of materials other than antigen is inadequate. The hypothesis that the virus is carried into the skin with the needle is rejected.

SECTION ON GASTROENTEROLOGY AND PROCTOLOGY

Founders Room, Sheraton-Cadillac Hotel, Detroit

Chairman: E. F. SLADEK, M.D., Traverse City
Secretary: R. L. FITTS, M.D., Grand Rapids

"Regional Enteritis"

SAMUEL F. MARSHALL, M.D., Boston, Massachusetts

The treatment of regional enteritis, to be at all successful, must be a combination of medical and surgical measures--not merely medical treatment alone or surgical treatment alone.

The high recurrence rate of approximately 30 per cent vividly emphasizes that either method, medical or surgical, is not the final word in the treatment of regional enteritis. If the diagnosis can be made early enough and the disease process recognized, the results of conservative medical measures are as good as those of early surgical methods. Surgical extirpation should be restricted to those patients in whom complications have developed, such as perforation, persistent hemorrhage from the intestinal tract, abscess and intestinal obstruction.

Although almost everyone now agrees that surgery is the accepted method of treatment for the majority of complicated cases of regional enteritis, there is still considerable controversy over the particular type of surgical procedure to be done and the results to be obtained by the various methods. At this clinic, the mortality of resection has been low, less than 3 per cent. We believe that extirpation of this disease process together with as many of the involved nodes in the mesentery as possible offers the greatest opportunity for complete eradication of the disease by preventing recurrence, eliminating the toxic process and obtaining a better nutritional state for the patient. It is true that ileotransverse colostomy has been used and advocated by many investigators on this subject but the majority of patients so treated are never quite well, they have persistent nutritional problems and

often show evidence of persistent sepsis. Resection and primary anastomosis can be carried out with an extremely low operative risk and offer a much greater opportunity for recovery from this disease. It must be admitted, however, that the recurrence rate after either type of surgical treatment is still too high and that continuation of medical therapy after operation is an important factor in the ultimate prognosis of this serious disease.

THURSDAY EVENING

September 25, 1952

STATE SOCIETY NIGHT

Grand Ballroom, Sheraton-Cadillac Hotel

P.M.

10:30 **An evening of entertainment for all registrants, their ladies and guests.**

Cabaret-style Dance and Floor Show
Host: Michigan State Medical Society
(Admission by card furnished to all upon registration)

ONLY ONE MORE DAY TO VISIT YOUR MANY FRIENDS IN THE EXHIBIT

FRIDAY MORNING

September 26, 1952

Fifth Assembly

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: RALPH W. SHOOK, M.D., Kalamazoo
Secretary: T. V. HOAGLAND, M.D., Detroit

A.M.

9:00 **"The Surgical Correction of Mitral Stenosis**

DWIGHT E. HARKEN, M.D., Boston, Massachusetts

Surgeon, Peter Bent Brigham Hospital, Boston; Surgeon and Chief of Department of Thoracic Surgery, Mt. Auburn Hospital, Cambridge, Mass.

9:30 **"Problems in the Diagnosis and Treatment of Syphilis"**

EVAN W. THOMAS, M.D., Albany, New York

Professor of Clinical Medicine, New York University; Bellevue Medical Center, N.Y.C.; Associate Physician Public Health (V.D. Control), New York State Health Department.

Some of the gaps in our understanding of the immunology and pathology of syphilis are mentioned. The greatest problem in the diagnosis of syphilis is to differentiate between active and inactive or permanently arrested infections. This differentiation is relatively easy in the primary and secondary stages before treatment. Following treatment of secondary syphilis the serologic tests for syphilis fail to become negative in about 20 per cent of non-relapsing cases for more than one year after treatment. The meaning of such prolonged seroresistance is considered.

In the absence of visible or palpable lesions, the differentiation between active and inactive late syphilis is oftentimes impossible except in neurosyphilis where the spinal fluid findings serve as a guide. The importance of this guide to the treatment of all types of late syphilis is discussed.

10:00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"Intestinal Obstruction"**

PHILIP THOREK, M.D., Chicago, Illinois

Chief Associate Professor, Department of Surgery, University of Illinois; Associate Professor of Surgery, Cook County Graduate School of Medicine; Diplomate, American Board of Surgery; Fellow, American College of Surgeons; Fellow, International College of Surgeons; Fellow, American College of Chest Physicians, American Association of Anatomists; Chief Surgeon, American Hospital; Attending Surgeon, Cook County Hospital; Senior Attending Surgeon, Alexian Brothers' Hospital.

The still too high mortality of intestinal obstruction stands as a glaring challenge to the medical profession in general. Memorized knowledge as to the number of conditions which may be associated with intestinal obstruction is of no diagnostic or therapeutic aid whatsoever. Intestinal obstruction as a symptom complex rather than a disease must be stressed.

With an aim toward simplification in diagnosis four simple questions are asked, the answers to which automatically point to proper diagnostic interpretation. Having obtained the diagnosis, a plan of therapy can be instituted. Such a plan is presented and its clinical applications are discussed thoroughly. By thus simplifying diagnosis and treatment do we attempt to lower the mortality of intestinal obstruction.

11:30 **"The Epilepsies, Their Diagnosis and Treatment"**

ROLAND P. MACKAY, M.D., Chicago, Illinois

Professor of Neurology, University of Illinois College of Medicine; Senior Attending Neuropsychiatrist, St. Luke's Hospital, Chicago; Attending Neurologist, Illinois Neuropsychiatric Institute.

The epilepsies or convulsive disorders may, for convenience, be divided into symptomatic and cryptogenic subgroups. The clinical types are described in detail and their significance discussed. They include grand mal, petit mal, and psychomotor seizures, the last mentioned being subdivided into ictal automatisms, ictal amnesic states, and ictal dreamy states. Additional clinical groups include myoclonic epilepsy and focal epilepsy which latter may be either motor or sensory in type.

Electroencephalography is a highly valuable laboratory method for the study of cases of convulsive disorders and throws light on most diseases of the brain. The abnormalities seen in the epilepsies consist of changes in the basic frequency, and the appearance of paroxysmal bursts of high voltage, high frequency waves or of slow waves. The occurrence of sharp spikes suggests an abnormal discharging focus. Abnormalities are apt to appear more readily during sleep. There is a significant but not an absolute correlation between electroencephalographic abnormalities and the clinical types of seizures. Consequently it is improper to speak of a "grand mal tracing" or "petit mal tracing," and each electroencephalogram must be interpreted in relationship to the known clinical features of each case.

Therapy, of course, can be prescribed only after a careful consideration of both clinical and electroencephalographic data and never upon the electroencephalographic phenomena alone. The treatment of the epilepsies demands the utmost in individualization. The various drugs and procedures used are thoroughly discussed with their specific indications and disadvantages.

12:00 **END OF FIFTH ASSEMBLY**

FRIDAY NOON

(No Luncheons)

September 26, 1952

12:00 to 1:00 p.m.

DISCUSSION CONFERENCE

Grand Ballroom, Sheraton-Cadillac Hotel

Leader: W. S. REVENO, M.D., Detroit
Participants: DANIEL C. DARROW, M.D., New Haven, Connecticut; GARFIELD G. DUNCAN, M.D., Philadelphia, Pennsylvania; DWIGHT E. HARKEN, M.D., Boston, Massachusetts; ROLAND P. MACKAY, M.D., Chicago, Illinois; EARL R. MILLER, M.D., San Francisco, California; EVAN W. THOMAS, M.D., Albany, New York; PHILIP THOREK, M.D., Chicago, Illinois; and CLAUDE E. WELCH, M.D., Boston, Massachusetts

FRIDAY AFTERNOON
September 26, 1952

Sixth Assembly

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: R. S. BREAKEY, M.D., Lansing
Secretary: C. J. COURVILLE, M.D., Detroit

P.M.

2:00 **"Fluid Requirements in Patients of Different Sizes"**

DANIEL C. DARROW, M.D., New Haven, Connecticut

Professor of Pediatrics, Yale University School of Medicine.

Fluid therapy will be considered in patients who have sustained loss of body water and electrolyte. Rational planning is based on:

(1) Replacement of deficits
(2) Administration of fluids to replace obligatory normal expenditure
(3) Additional water and electrolyte to replace abnormal expenditure.

Knowledge of the changes in intracellular as well as extracellular composition is needed for (1), and the amounts are related to body weight. Obligatory expenditure is related to metabolic turnover or heat production. Abnormal expenditure is related to abnormalities in urine and stools and the volumes of gastrointestinal fluid lost. The uses of fluids containing potassium as well as sodium, chloride and glucose will be discussed.

2:30 **"Recent Advances in Radiology"**

EARL R. MILLER, M.D., San Francisco, California

Professor of Radiology, University of California School of Medicine; Radiologist, University of California Hospital.

3:00 **INTERMISSION TO VIEW EXHIBITS**

3:30 **"The Surgical Management of Duodenal Ulcer"**

CLAUDE E. WELCH, M.D., Boston, Massachusetts

Associate Visiting Surgeon, Massachusetts General Hospital; Clinical Associate in Surgery, Harvard Medical School.

4:00 **"Management of Diabetes During Acute Complications"**

GARFIELD G. DUNCAN, M.D., Philadelphia, Pennsylvania

Director of the Medical Divisions, Benjamin Franklin Clinic and Pennsylvania Hospital, and Clinical Professor of Medicine, Jefferson Medical College, Philadelphia, Pennsylvania.

Every diabetic patient suffers from an acute complication sooner or later. Acute complications intensify the disturbances characteristic of diabetes and precipitate hazards which may threaten life.

The more dangerous of the acute complications are pyogenic infections, gastrointestinal disturbances in which vomiting and/or diarrhea are features, and vascular accidents notably occlusion of a coronary artery.

Febrile disturbances, in general, reduce the degree of and duration of the effectiveness of insulin. Three plans of insulin therapy are recommended for the control of the diabetes during acute complications based on the nature of the complications. (a) Some patients need only increases in the precomplication doses of insulin. (b) Others for a short time need regular insulin at four or six-hour intervals superimposed on the precomplication insulin therapy. (c) Those with more severe and prolonged complications need to have their precomplication insulin regimen replaced by regular insulin given at six-hour intervals, with the diet divided into four equal meals, one every six hours.

The management of diabetic coma is simplified by making an early—a bedside—diagnosis by simply testing for the degree of acetonemia when glycosuria is found. A 4-plus reaction for acetone in the plasma confirms the diagnosis and permits prompt institution of therapy. The amount of insulin given initially is regulated by the degree of acetonemia as determined by qualitative tests of serial dilutions of the plasma. The advantages of these simple measures have been amply proved.

4:30 **END OF SIXTH ASSEMBLY**

——Program of Sections——

FRIDAY
September 26, 1952
4:30 to 5:30 p.m.

SECTION ON RADIOLOGY

Founders Room, Sheraton-Cadillac Hotel, Detroit

Secretary: F. K. WIETERSEN, M.D., Birmingham
EARL R. MILLER, M.D., San Francisco, California

SECTION ON MEDICINE

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

Chairman: D. I. SUGAR, M.D., Detroit
Secretary: D. R. BOYD, M.D., Muskegon

"Description of the Selection of Patients for the Surgical Correction of Mitral Stenosis, with a Description of the Results After Surgery"

DWIGHT E. HARKEN, M.D., Boston, Massachusetts

SECTION ON GENERAL PRACTICE

English Room, Sheraton-Cadillac Hotel, Detroit

Chairman: E. M. SMITH, M.D., Grand Rapids
Secretary: C. J. WILLIAMS, M.D., Grosse Pte. Park

"Jaundice"

PHILIP THOREK, M.D., Chicago, Illinois

Jaundice, or hyperbilirubinemia, is an important subject to both the general practitioner and specialist alike, and always presents an interesting diagnostic challenge. One must have ways and means of co-ordinating and simplifying the subject so that with the diagnostic armamentarium at hand a diagnosis may readily be reached and proper therapy instituted. A thorough understanding of the pathologic physiology involved results in a more rapid and accurate diagnosis than the memorized knowledge of the hundred and one conditions which might be associated with this symptom. It is with this in mind that the subject is presented.

The value of Courvoisier's law is stressed. Pruritus as a diagnostic aid rather than a symptom is discussed.

It has been found advantageous to clinically classify jaundice into three groups, based upon the relationship of the lesion to the liver.

The use of four anatomic divisions of the common duct permits one to standardize the various operative procedures on this structure.

The diagnostic as well as the surgical do's and don't's are emphasized.

SECTION ON NERVOUS AND MENTAL DISEASES

Pan American Room, Sheraton-Cadillac Hotel, Detroit

Chairman: P. N. BROWN, M.D., Northville
Secretary: T. V. HOAGLAND, M.D., Detroit

"Memory as a Biologic Function"

ROLAND P. MACKAY, M.D., Chicago, Illinois

It appears that memory is a basic attribute of all living things, by which patterns of sensitivity and response, both inborn and acquired, are retained and progressively modified under the impact of experience. Memory is thus indispensable in all behavior, making it at once consistent and modifiable. A consideration of some of the classical psychologic features of memory indicates the extent to which it involves multi-modal processes and hence involves extremely widespread cerebral areas. In the higher animals and in man therefore, memory can have no precise localization and thus cannot be said to "reside" in the temporal lobe or in any other restricted area. In the simplest organisms memory seems to be dependent upon modifiable molecular structure; its mechanism in a nervous system is a most elusive function of neuronal networks by which topographic and sequential patterns of stimuli sensitize the network to subsequent stimuli in the same patterns, probably through the device of summation in reverberating circuits rather than by the facilitation of anatomical pathways. Sketchy and hypothetical though our present knowledge is, this dynamic approach to the physiology of memory promises much for our understanding of the behavior of living things.

5:30 **END OF SCIENTIFIC ASSEMBLY AND OF 1952 ANNUAL SESSION**

Technical Exhibits

Abbott Laboratories **Booth No. 46**
North Chicago, Illinois

Abbott presents a special product display featuring six of their latest laboratory developments. Included are ABBOCILLIN 800M, new high concentration penicillin product; DICALETS, balanced-formula vitamins and minerals for pregnancy and lactation; and DAYALETS, Abbott's new fishless, burpless multivitamin tablets. Other products to be displayed are OPTILETS, SELSUN and SUCARYL.

Alkalol Company **Booth No. 94**
Taunton, Massachusetts

The Alkalol Company, Taunton, Massachusetts, will feature Alkalol, the balanced, alkaline, saline solution for the treatment of mucous membranes and irritated tissues. It is bland, nontoxic, and effective, and has been a favorite since 1896. We are also showing Irrigol, a powder which in solution makes an aseptic, slightly astringent vaginal douche. It is widely used also for colonic irrigations and as an effective rectal enema.

A. S. Aloe Company **Booth No. 73**
St. Louis, Missouri

Visit Booth No. 73 where the Aloe representative will show you a cross section of the complete line of physicians' equipment and supplies carried by the A. S. Aloe Company. Highlighted will be New Model Steeline—tomorrow's treatment room furniture today —featuring the body contour table top, magnetic door catches and advanced design all in new decorators' colors.

Americana Corporation **Booth No. 31**
Chicago, Illinois

All members of the Michigan State Medical Society are very cordially invited to visit our Booth No. 31 where we will have on display, for their inspection, the mid-century printing of the *Encyclopedia Americana* and also the fortieth anniversary edition of the *Book of Knowledge*. Both will be combined in a very unique combination offer. Our Mr. Armin Eastman will be in attendance.

American Hospital Supply Corporation **Booth No. 25**
Evanston, Illinois

Scientific Products Division, American Hospital Supply Corporation, will exhibit Baxter intravenous solutions, including Travert, the new invert sugar solution providing twice the calories as dextrose in the same infusion time; Baxter blood transfusion and plasma equipment, together with the complete line of Baxter expendable accessories for the intravenous solutions and blood and plasma bottles.

Ames Company, Inc. **Booth No. 33**
Elkhart, Indiana

The Ames DIAGNOSTIC KIT will be featured. This small kit (3 x 9 inches) contains CLINITEST, ACETEST, BUMINTEST, and HEMATEST, simplified tests for urine-sugar, acetest, albumin, and occult blood. This kit is designed for the physician's office, small laboratory, hospital floor use, etc. The Ames representatives will be demonstrating these tests.

Armour Laboratories **Booth No. 19**
Chicago, Illinois

You are cordially invited to attend The Armour Laboratories' exhibit where our representatives will be pleased to discuss with you ACTHAR Gel, The Armour Laboratories' Brand of Adrenocorticotropic Hormone; TRYPTAR; the Armatinic products; the Crystamin products; and Thyroid.

Ayerst, McKenna & Harrison, Ltd. **Booth No. 17**
New York, New York

Physicians attending the Michigan State Medical Society Session are cordially invited to visit the Ayerst booth where you will receive a warm welcome. Our representatives will be there to answer any inquiries relative to "Premarin" with Methyltestosterone, "Clusivol," "Antabuse," or any other inquiries relative to all products of our manufacture.

Baby Development Clinic **Booth No. 93**
Chicago, Illinois

BABY DEVELOPMENT CLINIC presents psychological and emotional aspects of early feeding in visual as well as printed form. Ideal for use of doctors, nurses, as well as teachers, and others who are in contact with expectant parents, medical students or nurses in training.

MATERNITY COUNSELLING SERVICE — a courtesy service available to doctors for their maternity patients—relieves doctors of discussing layette needs and other preparationss for home and baby. No charge or obligation to doctor or patients. Supported by firms included in exhibit.

Baker Laboratories, Inc. **Booth No. 59**
Cleveland, Ohio

Baker's Modified Milk (Carbohydrate added) and Varamel (no Carbohydrate added) are made especially for infant feeding, from Grade A milk (U. S. Public Health Service Milk Code), which has been modified by replacement of the milk fat with animal and vegetable oils and by the addition of vitamins and iron.

Bard-Parker Company, Inc. **Booth No. 41**
Danbury, Connecticut

Genuine Bard-Parker "Rib-Back" surgical knife blades, "the blade that assures cutting efficiency." A quality product that makes for blade economy; B-P handles of various types; Bard-Parker Germicide—a sporicidal solution; Bard-Parker Chlorophenyl; instrument sterilizing containers; The Reese Dermatome—for simpler, more accurate split-skin grafts with the Dermatape technique.

Barry Laboratories, Inc. **Booth No. 21**
Detroit, Michigan

Barry Laboratories, Inc., will display the most up-to-date advances in diagnostic and therapeutic products in both allergens and sterile injectables. A representative will be in constant attendance to furnish information and discuss any products on display.

Beech-Nut Packing Company **Booth No. 26**
New York, New York

BEECH-NUT STRAINED BANANA and the new CORN CEREAL will be featured at this booth. Nutritionists will be in attendance to answer questions

regarding the nutritive value and use of these foods as well as of the other Beech-Nut Strained and Junior Foods and the Beech-Nut Cereals.

The Borden Company **Booth No. 29**
New York, New York

Borden representatives will be more than pleased to discuss a new powdered infant food with you. BREMIL is a completely modified milk in which nutritionally essential elements of cow's milk have been adjusted in order to supply the nutritional requirements of infants deprived of human milk. Also exhibited will be MULL-SOY, DRYCO, BIOLAC, and other prescription products.

Brooks Appliance Company **Booth No. 16**
Chicago, Illinois

The Brooks Appliance Company will exhibit and describe in detail the technique of applying the combination pressure bandages, the moist medicated Primer plus the Elastic Adhesive Dalzoflex which are used in treating leg ulcers and phlebitis. Elastic Stockings, the Nulast Elastic Crepe Bandages and Surgical Instruments will also be displayed.

Brown & Williamson Tobacco Corp. **Booth No. 83**
Louisville, Kentucky

Doctors and guests alike are cordially invited to visit the booth of the Brown & Williamson Tobacco Corporation. Their booth will exhibit VICEROY (filter tip) Cigarettes, a brand of particular interest to the medical profession. Gift packages of VICEROY Cigarettes will be presented to those who register at the VICEROY booth.

Burdick Corporation **Booth No. 85**
Milton, Wisconsin.

Burdick Physical Medicine Equipment to be exhibited will include their Direct-Recording Electrocardiograph, which is distributed in Michigan by The G. A. Ingram Company of Detroit. Other Burdick products to be featured include F.C.C. approved Diathermy equipment, Ultraviolet and Infra-red Lamps and the new McLellan Suction Unit.

Burroughs Wellcome & Co. (U.S.A.) Inc. **Booth No. 55**
Tuckahoe, New York

AEROSPORIN® Sulfate: Polymyxin B. Sulfate, a new antibiotic. Effective against *Pseudomonas aeruginosa.* Destroys most other gram-negative bacilli.

POLYSPORIN®: Polymyxin B—Bacitracin Ointment. Broad spectrum for all pyogenic infections, including external ear infections, styes, acne, furuncles. Rarely sensitizes. Resistance rarely develops.

Camel Cigarettes **Booths Nos. 35, 36**
New York, New York

CAMEL Cigarettes will mark your initials on an attractive plastic cigarette case filled with a package of those mild, flavorful CAMELS. This exhibit features a display of some of the tobaccos used in blending this famous cigarette which leads all other brands by many billions.

Carnation Company **Booth No. 38**
Los Angeles, California

You are cordially invited to visit the Carnation Company Booth No. 38 where you will see an attractive display featuring colorful translites of famous Carnation Babies. Medical representatives will explain the reasons why Carnation Milk deserves consideration as your first choice for infant feeding, child feeding and general diet uses. Valuable literature will also be available for distribution.

Ciba Pharmaceutical Products, Inc. **Booth No. 11**
Summit, New Jersey

The Ciba exhibit will feature APRESOLINE, a phthalazine derivative which is an orally effective and relatively safe therapy in hypertension of diverse etiology.

Representatives in attendance will be very glad to discuss and to provide literature on this and other Ciba products.

Coca-Cola Company **Booth No. 99**
Atlanta, Georgia

Ice-cold Coca-Cola served through the co-operation and courtesy of the Detroit Coca-Cola Bottling Company and The Coca-Cola Company.

Coles Corporation **Booth No. 27**
Philadelphia, Pennsylvania

COLES CORPORATION will exhibit a full complement of surgical equipment of advanced design. Included are precision cutting instruments, both portable and floor models, which permit the use of varied electronic surgical methods to meet the exacting surgical needs of the general practitioner, gynecologist, or proctologist, including certain major surgery interventions. SEE the Portable RADIOSURG SCALPEL and the new RADIOTOME Surgery Unit— a semi-hospital combination tube and gap-type cutting unit. THE RADIOTOME employs a dual foot pedal control and is amply powered to meet the requirements for a moderate sized operating room unit. We invite your inspection of these quality units.

Desitin Chemical Company **Booth No. 65**
Providence, Rhode Island

DESITIN OINTMENT, the pioneer in external cod liver oil therapy. Indications: diaper rash, slow healing wounds, burns of all degrees, lacerations, hemorrhoids and fissures.

DESITIN POWDER, a unique, dainty medicinal powder saturated with cod liver oil.

DESITIN HEMORRHOIDAL SUPPOSITORIES with COD LIVER OIL, coats ano-rectal area with soothing, lubricating cod liver oil, gives prompt relief of pain, allays itching.

DESITIN LOTION, the original cod liver oil lotion, soothing, protective, mildly astringent and healing, in non-specific dermatitis, pruritus, poison ivy, etc.

Detroit Creamery Company **Booth No. 97**
Detroit, Michigan

Dictaphone Corporation **Booth No. 15**
Detroit, Michigan

The most successful dictating machine in history—the electronic Dictaphone Time-Master—will be featured at the Dictaphone booth.

With its unbreakable plastic Dictabelt record, the new Time-Master saves time and effort in every branch of the medical profession. Be sure to see and try the Time-Master and get your copy of "Help for the Busiest Man in Town" at the Dictaphone booth.

Dietene Company **Booth No. 52**
Minneapolis, Minnesota

Visit our exhibit and examine the Free Diet Service for physicians. The diets are nutritionally well-balanced, easy to follow and made to appear as if they were typed in your office.

MERITENE, the economical and palatable whole protein supplement and DIETENE, the "Council - Accepted" reducing supplement will be on display.

Doak Company, Inc. **Booth No. 30**
Cleveland, Ohio

Doak Company, Inc., specializing in dermatological preparations for over thirty years, present the following preparations: Buro-Sol Powder, Buro Sol Cream, Spersol, Solar Cream, Normaderm, Tarpaste and the new products Dalibour Powder and Derma Packs.

Doho Chemical Corporation **Booth No. 10**
New York, New York

Doho Chemical Corporation is pleased to exhibit AURALGAN, the ear medication for the relief of pain in Otitis Media and removal of Cerumen; RHINALGAN, the nasal decongestant which is free from systemic or circulatory effect and equally safe to use on infants as well as the aged; and the NEW OTOSMOSAN, the effective, non-toxic ear medication which is Fungicidal and Bactericidal (Gram negative-Gram positive) in the suppurative and aural dermatomycotic ears. Mallon Chemical Corporation, subsidiary of the Doho Chemical Corporation, is also featuring RECTALGAN, the liquid topical anesthesia, also Bactericidal and Fungicidal for control of secondary invaders, particularly recommended for treatment of mold infections (monilia) occurring after anti-biotic therapy; also for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing.

Eaton Laboratories, Inc. **Booth No. 70**
Norwich, New York

Furacin,® an effective antibacterial agent in the presence of exudates is offered, in a new dosage form—Furacin Nasal *plain* for atrophic rhinitis, sinusitis and postoperative treatment. This is a companion product to Furacin Nasal with ephedrine.

When pregnancy is contraindicated Lorophyn Suppositories offer an effective, simple technic with high patient acceptance.

Eisele & Company **Booth No. 77**
Nashville, Tennessee

Eisele & Company will display their line of clinical thermometers, hypodermic syringes—both the regular type and Interchangeables—hypodermic needles, Sanelastic bandages and specialty glassware.

H. G. Fischer & Company **Booth No. 67**
Detroit, Michigan

At Booth No. 67 inspect H. G. Fischer & Co.'s modern, efficient, low priced x-ray and physical therapy equipment. Let their representatives point out many features of advantage in these units and other models not on display. Your visit welcome—No obligation.

C. B. Fleet Company, Inc. **Booth No. 8**
Lynchburg, Virginia

C. B. Fleet Co., Inc., cordially invites you to visit Booth No. 8. Increasingly, during the past fifty years, to the medical profession, sodium phosphate has come to mean Phospho-Soda (Fleet), the pure, stable, aqueous solution of the two U.S.P. sodium phosphates. There is only ONE Phospho-Soda (Fleet).

Freeman Mfg. Company **Booth No. 68**
Sturgis, Michigan

For more than sixty years Freeman has been engaged in making surgical supports and elastic hose. During that time we have worked closely with members of the medical profession. Their assistance has proved invaluable in enabling us to maintain the highest standards of quality and design.

We particularly invite your inspection of our complete line of orthopedic supports being exhibited at the show.

Geigy Pharmaceuticals **Booth No. 49**
New York, New York

BUTAZOLIDIN T.M. a totally new, synthetic, non-hormonal rheumatolytic and analgesic with an exceptionally broad field of usefulness in rheumatism and allied disorders, will be featured. Also on display will be Council Accepted TROMEXAN® a new, safer, faster-acting, less-cumulative, oral anticoagulant; EURAX® Cream, a new, long-acting, non-sensitizing, antipruritic and scabicide; and PANPARNIT® indicated for symptomatic relief of Parkinson's Disease.

General Electric Co.—X-Ray Dept. **Booth No. 72**
Milwaukee, Wisconsin

General Electric X-Ray extends a cordial invitation to visit their exhibit. Representatives who call on you will look forward to your visit, and if circumstances beyond our control do not prevent, new equipment will be on display. In any case, we hope that this meeting will again afford an opportunity to visit with you.

Gerber Products Company **Booth No. 34**
Fremont, Michigan

Gerber's of Michigan is proud to serve Michigan's physicians and, through them, Michigan's future citizens.

Gerber's Fremont plant processes the best of the State's garden and orchard produce into the wide variety of baby foods that makes prescription selectivity easy for every baby's doctor.

Gerber's professional representatives look forward to greeting you at your Annual Session.

Hack Shoe Company **Booth No. 3**
Detroit, Michigan

It wouldn't be a Michigan State Medical Society Annual Session without this long-time friend of the profession on hand with a display of supportive-type footwear. Over the years, whenever a doctor of medicine has occasion to think of prescription footwear for a patient, the name HACK is the one which comes to his mind—and prescription pad.

This year, the emphasis will be on dressing up therapeutic footwear—sugar-coating what for so long has been a bitter pill for young women forced to wear "Old Ladies' Running Shoes." There are some good-looking shoes for you, too, Doctor.

Hanovia Chemical & Mfg. Company **Booth No. 54**
Newark, New Jersey

See Hanovia's new short wave diathermy, possessed of special features, orificial and general body irradiation; ultraviolet quartz lamps, infrared lamps, black light for diagnostic purposes. Competent and courteous representatives will be on hand to greet you.

J. F. Hartz Company **Booth No. 64**
Detroit, Michigan

The J. F. Hartz Company is pleased to again have the opportunity to display its Laboratory Controlled Pharmaceuticals and the latest in office and diagnostic equipment. We particularly call your attention to the Microtherm "Radar Type" diathermy which we will be happy to demonstrate for you at this meeting.

H. J. Heinz Company **Booth No. 53**
Pittsburgh, Pennsylvania

Stop at the Heinz exhibit for these: Nutritional Data, Nutritional Observatory. Do you need Baby Gift Folders for distribution among your patients? Have you seen the additions to Heinz Baby Food line—Pre-Cooked Barley Cereal? New Junior Foods are—Sweet Potatoes, Chocolate Pudding, Butterscotch Pudding, and Macaroni, Tomato, Beef and Bacon.

Hoffmann-La Roche, Inc. **Booth No. 76**
Nutley, New Jersey

Roche will feature GANTRISIN, the more soluble sulfonamide which has a wider antibacterial spectrum. GANTRISIN is highly effective in the treatment of systemic and urinary tract infections. Stop at the Roche booth where members of the field staff will be glad to discuss this more effective and better tolerated sulfonamide.

Holland-Rantos Company, Inc. **Booth No. 92**
New York, New York

Holland-Rantos will feature NYLMERATE SOLUTION, a concentrated trichomonicidal, fungicidal and bactericidal preparation used in recommended dilutions as a vaginal douche—either alone or as an adjunct to Nylmerate Jelly. Representatives will gladly answer inquiries regarding Nylmerate preparations, KOROMEX products for *dependable* contraceptive protection, or other specialties of special interest to you.

G. A. Ingram Company **Booth No. 84**
Detroit, Michigan

The G. A. Ingram Company will exhibit a complete line of diagnostic instruments as well as orthopedic instruments which will prove to be of special interest to the profession.

C. B. Kendall Company **Booth No. 78**
Indianapolis, Indiana

Constant efforts in the development laboratories to provide products reflecting the most advanced medical trends, pharmaceutical elegance, and improved production methods will be exemplified in the C. B. Kendall Co. exhibit. Outstanding products of accepted merit and newer products of recent development will be displayed and discussed with visiting physicians by informed representatives.

Kremers-Urban Company **Booth No. 74**
Milwaukee 1, Wisconsin

Kremers-Urban Professional Service Representatives will welcome the opportunity to meet our many Michigan friends. K-U Council-accepted medications and new research developments will be displayed. We hope you will stop and visit with us.

A. Kuhlman & Company **Booth No. 91**
Detroit, Michigan

We invite you to visit our display and see an excellent line of Surgical and Diagnostic Instruments. We are also showing the latest design of Medical Office Furniture and FCC Approved Short Wave Diathermies.

Lea & Febiger **Booth No. 87**
Philadelphia, Pa.

Schedule plenty of time to see the Lea & Febiger display at booth No. 87. New books include McManus, *Progress in Fundamental Medicine;* Master, Walters and Garfield, *Blood Pressure and Hypertension;* Lewin on *The Knee;* Bonica, *The Management of Pain;* Collins, *Principles and Practice of Anesthesiology;* Herbut, *Urological Pathology;* Master, Moser and Jaffe, *Cardiac Emergencies and Heart Failure;* and other works of medical importance.

Lederle Laboratories **Booth No. 51**
New York, New York

You are cordially invited to visit our exhibit in Booth No. 51, where you will find representatives who are prepared to give you the latest information on Lederle products.

Liebel-Flarsheim Company **Booth No. 7**
Cincinnati, Ohio

The Liebel-Flarsheim Company cordially invites you to visit Booth No. 7 in which their latest diathermy apparatus will be available for examination and demonstration. Capable representatives will be on hand at all times and we hope you will stop by so that we may become acquainted.

Eli Lilly & Company **Booth No. 90**
Indianapolis 6, Indiana

Your Lilly medical service representative cordially invites you to visit the Lilly exhibit located in Booth No. 90. Featured will be a demonstration of functional packaging as an aid to medical practice. Modern manufacturing departments will be illustrated. Literature on new therapeutic developments will be available.

J. B. Lippincott Company **Booth No. 1**
Philadelphia, Pennsylvania

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

M & R Laboratories **Booth No. 62**
Columbus, Ohio

A QUARTER-CENTURY OF PROGRESS IN INFANT NUTRITION
M&R NUTRITION RESEARCH SERVICE

Your SIMILAC representatives are happy to take part in this meeting. They are pleased to have the opportunity to discuss with you the role of SIMILAC in infant feeding. They have for you the latest Pediatric Research Conference reports. Current reprints of Pediatric nutritional interest are also available.

Maico Hearing Service **Booth No. 86**
Detroit-Grand Rapids, Michigan

Maico Precision Hearing Aids are fitted in such a way that one's closest friends would never know an instrument was being worn. Scientific adjustments to the individual hearing loss insures maximum results—complete satisfaction is guaranteed to all physicians' patients referred to our offices. Ninety per cent of all precision hearing test instruments used in America by physicians are Maico.

Marion Phillips Maternity Preparations. **Booth No. 69**
Rochester, New York

S. E. Massengill Company **Booth No. 45**
Bristol, Tennessee

You are invited to visit Booth No. 45. Several Massengill specialty products are on display and the feature preparation is the new Tablets Aminodrox. Aminodrox permits wider usefulness for Aminophylline through the dependable blood levels that can be maintained with oral medication. Representatives are glad to discuss the new Tablets Aminodrox with you, and samples and literature will be available upon request.

Mead Johnson & Company **Booth No. 88**
Evansville, Indiana

MEAD JOHNSON & COMPANY, Evansville, Indiana, will feature Lactum and Dalactum, convenient formulas of evaporated milk containing Dextri-Maltose; three water-soluble vitamin preparations, Poly-Vi-Sol, Tri-Vi-Sol and Ce-Vi-Sol; Fer-In-Sol, a palatable, highly concentrated solution of ferrous sulfate. Also Mulcin, a pleasingly flavored vitamin emulsion, for teaspoonful dosage, as well as four Pablum cereals, including Barley and Rice.
Representatives in attendance will be glad to furnish information regarding the above products.

Medical Arts Surgical Supply Company. **Booth No. 81**
Grand Rapids, Michigan

Medical Arts Surgical Supply Company of Grand Rapids will occupy Booth No. 81 showing the new Ritter chair-table, many new diagnostic and treatment items including new instruments.

Medical Protective Company **Booth No. 40**
Fort Wayne, Indiana

Having completed another year in which not a single policyholder suffered involuntary loss from his own pocket in a malpractice claim or suit defended by this unique organization, despite large losses reported elsewhere, The Medical Protective Company, Specialists in Professional Protection Exclusively since 1899, invite your visit to Booth No. 40. Answers to problems in the Doctor-Patient relationship are yours for the asking.

Merck & Company, Inc. **Booth No. 80**
Rahway, New Jersey

MERCK & CO. INC. is featuring CORTONE, HYDROCORTONE, NALLINE, and other medicinal preparations.
CORTONE has produced striking clinical improvement in rheumatoid arthritis and related rheumatic diseases; bronchial asthma; eye diseases including non-specific iritis, iridocyclitis and uveitis; and skin diseases including cases secondary to drug reactions.
HYDROCORTONE is recommended for injection into the articular cavity of a rheumatoid or osteoarthritic joint.
NALLINE is a specific antidote in the treatment of overdosage with morphine and its derivatives, as well as meperidine and methadone.
Representatives at the Merck booth will be glad to provide information on these and other medicinal preparations such as Antibiotics, NEO-ANTERGAN, URECHOLINE, and VINETHENE.

Wm. S. Merrell Company **Booth No. 95**
Cincinnati, Ohio

For prompt, effective and COMFORTABLE relaxation of gastrointestinal smooth muscle spasm Merrell presents BENTYL Hydrochloride.
BENTYL is a high milligram potency non-narcotic antispasmodic with twofold musculotropic and neurotropic action; effective therapeutically without atropine-like side actions in functional gastrointestinal disorders.
BENTYL is particularly suited for prolonged administration without habituation or increased tolerance.

Michigan Medical Service **Booth No. 4**
Detroit, Michigan

Representatives will be present to give full particulars regarding the Doctors of Michigan Voluntary Prepaid Medical-Surgical Plan. All your questions will be answered and any problems handled.
Various statistical charts showing progress for the past year and from inception to date will be available for your inspection.

C. V. Mosby Company **Booth No. 61**
St. Louis, Missouri

The latest in medical literature can be found at the C. V. Mosby Company Booth No. 61, where you are invited to visit and browse at your leisure. Among the recent releases are: Hermann "Diseases of Heart and Arteries," Traut "Rheumatic Diseases in Theory and Practice," Litzenberg "Synopsis of Obstetrics," Kosmak "Transactions Fifth American Congress on Obstetrics and Gynecology," and many others.

National Drug Company **Booth No. 9**
Philadelphia, Pennsylvania

The National Drug Company, pioneer in the clinical application of resin therapy, will feature Resion, an intestinal adsorbent; Resinat H-M-B, a polyamine exchange resin with homatropine methylbromide for the treatment of peptic ulcer; and Natrinil, a cation exchange resin for the control of edema. Trained representatives will be in attendance to discuss our resin preparations and other specialties: ACTH, Ammivin, AVC Improved, Benat, DTP Vaccine, Natolone, as well as any of National's vast array of pharmaceutical and biological products.

Nepera Chemical Company, Inc. **Booth No. 47**
Yonkers, New York

Nestlé Company, Inc. **Booth No. 66**
Colorado Springs, Colorado

You are cordially invited to visit Nestlé's Booth No. 66, where specially qualified representatives will be on hand to answer your questions on any of Nestlé's milk products—already best known and most used for babies 'round the world. New pieces of valuable literature will also be available.

Wm. R. Niedelson Company **Booth No. 13**
Detroit, Michigan

Visit our booth for the latest technical advances in office routine E.K.G.'s—B.M.R.'s and X-ray. The newest models of the *Jones Metabolism Equipment*

line and *Electro-Physical Lab. Cardiotrons* will be on exhibit.
Literature for the *Profexray* models, as well as other descriptive material, will be available at our exhibit.

Noble-Blackmer, Inc. **Booth No. 5**
Jackson, Michigan

Your friendly representatives from Jackson will be at Booth No. 5 to show you the latest Hamilton office furniture, the Birtcher Bandmaster, Crystal Controlled FCC approved Short-Wave Diathermy and "Light Where You Want It" with Castle office lights.

Ortho Pharmaceutical Corporation **Booth No. 44**
Raritan, New Jersey

ORTHO cordially invites you to visit their exhibit at Booth No. 44. The Ortho display will feature PRECEPTIN® vaginal gel, their new product for conception control designed for use without a vaginal diaphragm. Preceptin vaginal gel has achieved an outstanding record of clinical effectiveness and has been widely acclaimed by the medical profession. Your inquiries on Preceptin vaginal gel are invited.

Parke, Davis & Company **Booth No. 28**
Detroit, Michigan

Medical Service Members of the PARKE, DAVIS & COMPANY staff will be in daily attendance at the exhibit for consultation and discussion of products of particular interest to Society members at this time. Important specialties such as Chloromycetin, Penicillin S-R, Benadryl, Oxycel, Thrombin Topical, Surital, and others will be featured.

Pelton & Crane Company **Booth No. 75**
Detroit, Michigan

The Pelton FL-2 Autoclave reduces minutes to seconds between sterilizing periods. Its 6″ x 12″ chamber is surrounded by an outer jacket that generates and stores steam under pressure for immediate use at any time. Built sturdily of brass and bronze, it will last for years.

Pet Milk Sales Corporation **Booth No. 18**
St. Louis, Missouri

Specially trained representatives will be in attendance to discuss the use of Pet Milk in infant feeding, and to present many services that are time-savers for busy physicians. Miniature Pet Milk cans will be given to visitors at the exhibit.

Philip Morris & Company, Ltd. **Booth No. 6**
New York, New York

Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

Picker X-Ray Corporation **Booth No. 37**
White Plains, New York

The Picker X-Ray Corporation invites you to visit its exhibit where the latest accessories and equipment available for x-ray work are on display. A staff of technical specialists will be pleased to assist you with any x-ray planning or technical problem.

Procter & Gamble Company **Booth No. 20**
Cincinnati, Ohio

The Procter & Gamble Company offers a series of time-saving leaflet pads for doctors, "Instructions—Bathing a Patient in Bed," "Instructions—Routine Care of Acne," "Instructions—Bathing Your Baby," "Hygiene of Pregnancy," "Home Care of Bedfast Patient," and "Instructions—Sickroom Precautions." There will also be samples of other material prepared for physicians. Mrs. Christyne Schwab, in charge.

Professional Management **Booth No. 82**
Battle Creek, Michigan

PM

Residents and Interns, as well as physicians now in practice, are invited to Booth No. 82 for consultation with PM regarding Office Records—Office Design—Partnership Arrangements—Fees—Locations, Taxes or Estate Problems.

Randolph Surgical Supply Company **Booth No. 50**
Detroit, Michigan

Randolph Surgical Supply Company will exhibit outstanding new designs and finishes in Doctors' office equipment. On hand to greet our many friends will be such old timers as Cliff Randolph, Harold Stormhafer and Art Rankin, and a few of our young cubs always. "For Finer Equipment."

A. H. Robins Company, Inc. **Booth No. 12**
Richmond, Virginia

A. H. Robins Company exhibit is featuring PHENAPHEN and PHENAPHEN WITH CODEINE, "the complete analgesics"; and ROBITUSSIN, antitussive-expectorant for rational cough therapy. Robins' Medical Service Representatives welcome the privilege of discussing with physicians attending the Assembly these and other products in the company's line of prescription specialties.

Rystan Company, Inc. **Booth No. 39**
Mount Vernon, New York

Rystan will feature Chloresium Ointment and Solution (plain), water-soluble chlorophyll preparations providing tissue-repairing and deodorizing properties for treatment of wounds, burns, ulcers and dermatoses. Also exhibited will be Chloresium Mucinoid, combining chlorophyll and antacids in mucilaginous okra for peptic ulcer, and Chloresium Tablets, the high-concentration chlorophyll deodorizing tablet.

Sandoz Pharmaceutical Division **Booth No. 60**
New York, New York

Physicians attending the Michigan State Medical Society Convention are cordially invited to visit the Sandoz Pharmaceuticals display which will feature the following:
HYDERGINE—a new approach and new product for hypertension and peripheral vascular diseases.
CAFERGOT—the first effective oral preparation for the treatment of Migraine and related headaches.
BELLERGAL—a time-tested preparation for use in functional disorders.
A new handbook listing our products will be available and representatives in attendance will gladly answer any questions about these and other Sandoz products.

W. B. Saunders Company **Booth No. 2**
Philadelphia, Pennsylvania

Among the many new books and new editions available for your inspection at the Saunders Exhibit will be: "Recent Advances in Medicine and Surgery" from the Graduate School of Medicine of the University of

Pennsylvania; Shaffer & Boyd's "Correlative Cardiology"; Lewis' "Dermatology"; Salter's "Pharmacology"; Alexander's "Treatment of Mental Disorders"; Bland's "Clinical Use of Fluid and Electrolyte"; Cecil's "Specialties in General Practice"; Kroger & Freed's "Psychosomatic Gynecology"; and many others.

Schering Corporation **Booth No. 22**
Bloomfield, New Jersey

G. D. Searle & Company **Booth No. 63**
Chicago, Illinois

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be Banthine, the true anticholinergic drug for the treatment of peptic ulcers; Dramamine, for the prevention and active treatment of motion sickness; and Alidase, Searle brand of hyaluronidase which permits subcutaneous feedings at intravenous speed. Other time proven products of Searle Research on which information may be obtained are Searle Aminophyllin in all dosage forms, Metamucil, Ketochol, Floraquin, Kiophyllin, Diodoquin, Pavatrine, and Pavatrine with Phenobarbital.

Sharp & Dohme, Inc. **Booth No. 24**
Philadelphia, Pennsylvania

Research data relative to the potentiating effect of the antibiotics, bacitracin and tyrothricin, are featured in the Sharp & Dohme booth. The synergistic effect of penicillin in conjunction with the sulfonamides and clinical data on the use of vitamin B12 are also of major interest. Our representatives will welcome your visit.

Smith, Kline & French Laboratories **Booth No. 42**
Philadelphia, Pennsylvania

We extend to you a cordial invitation to visit our booth where "Drilitol," SKF's new antibiotic nose drop for local use in upper respiratory disorders will be featured. Our representatives will be happy to discuss this new product containing two antibiotics not in use systemically; anti-gram negative polymyxin and anti-gram positive gramicidin.

E. R. Squibb & Sons **Booth No. 89**
New York, New York

The Stuart Company **Booth No. 43**
Pasadena, California

Your Michigan Stuart representative issues a cordial invitation to all members of the State Medical Society to visit the Stuart booth. All of the well known Stuart products will be on display.

Testagar & Company, Inc. **Booth No. 14**
Detroit, Michigan

The professional service representatives of Testagar & Co., Inc., will be very pleased to welcome their many friends to view many new modern developments in the pharmaceutical field which will be displayed at Booth No. 14. Literature on some of the latest developments in the pharmaceutical field will be available. Vials and ampuls will be displayed, such as, Sodium Ascorbate, Testosterone Propionate, Heparin, etc. Requests for samples, literature, or technical information will be welcome.

Travenol Laboratories, Inc. **Booth No. 98**
Morton Grove, Illinois

Pyromen® is a sterile, nonprotein, non-antigenic bacterial component in a colloidal dispersion for parenteral use. Pyromen® is a stimulant for the endocrine and reticulo-endothelial systems, proven of value in the treatment of certain skin disorders, eye disorders, and allergies.

The Upjohn Company **Booth No. 57**
Kalamazoo, Michigan

It is the sincere desire of The Upjohn Company to make some definite contribution to the success of the 1952 meeting. Stop by at Booth No. 57 to relax and discuss topics of mutual interest.

U. S. Vitamin Corporation **Booth No. 96**
New York, New York

See the "oil-in-water" demonstration of liposoluble vitamins A and D made completely water soluble . . . a vitamin technical achievement originated and developed by the U. S. Vitamin Corporation Research laboratories.

Three pharmaceutical firsts . . . Vi-Syneral Vitamin Drops—multivitamins in drops solution; Vi-Syneral Injectable—multivitamin parenteral solution; and now Vi-Aqua Therapeutic—aqueous multivitamins in capsules . . . for more rapid absorption, greater therapeutic activity, shorter treatment time.

We cordially invite you to our booth for detailed literature and professional samples.

Vaisey-Bristol Shoe Company, Inc. **Booth No. 32**
Rochester, New York

Representatives will explain the diagnostic value of Jumping Jack shoes and the criteria for determining whether the early walking child is strengthening his foot by proper foot function or is possibly damaging it by walking poorly.

Jumping Jack shoes are not "corrective" shoes but representatives are equipped to discuss corrective wedging which may be installed in the shoes by prescription. Of especial interest is the Sincock system of determining the precise amount of correction needed to rectify a faulty gait. Many doctors have lauded Dr. Sincock's empirical method as "genius."

Varick Pharmacal Company **Booth No. 56**
New York, New York

Varick Pharmacal Co., Inc.—E. Fougera & Co., Inc., cordially invite physicians to discuss with Professional Service Representatives new preparations of importance to their everyday practice. Descriptive literature and samples of all products will be available.

Westinghouse X-Ray Company **Booth No. 79**
Detroit, Michigan

See the model X-Ray Department in the Westinghouse Booth. It's a miniature, well-planned, modern hospital X-ray Department under a clear plastic dome. There will also be a four-bank illuminator with translites, and the new Baby Positioner will be there for you to inspect. Come in and browse around, then relax in a comfortable chair.

White Laboratories **Booth No. 48**
Kenilworth, New Jersey

Winthrop-Stearns, Inc. **Booth No. 71**
New York, New York

WINTHROP-STEARNS, INC., New York, invite you to visit Booth No. 71, where the following products will be featured—TELEPAQUE, the new highly effective and well tolerated oral cholecystopaque medium. Gives denser, clear cut pictures of the gallbladder, and, in a substantial number of cases, also permits visualization of the biliary ducts; MILIBIS SUPPOSITORIES, new, highly effective specific against trichomonal, monilial, bacterial (nongonococcal) and mixed vaginitis; NEOCURTASAL IODIZED, trustworthy salt without sodium, with the addition of 0.01 per cent potassium iodide.

Wyeth Incorporated **Booth No. 58**
Philadelphia, Pennsylvania

You are cordially invited to visit the display of Wyeth Incorporated. This will feature THIOMERIN®, a recently developed, effective mercurial diuretic adaptable to self administration, and WYDASE®, highly purified hyaluronidase with a wide range of clinical applications. Representatives will be on hand to discuss and supply literature concerning these and other widely prescribed Wyeth ethical specialties.

Zimmer Manufacturing Company **Booth No. 23**
Warsaw, Indiana

Mr. Fisher, your Zimmer distributor, extends a most cordial invitation to the members of the Michigan State Medical Society and hopes they will visit his exhibit at Booth No. 23. A complete line of fracture appliances will be on display. ITEMS OF SPECIAL INTEREST INCLUDE THE EICHER, MINNEAPOLIS ORTHOPEDIC, NADEN REITH AND JUDET PROSTHETIC HEADS AND INSTRUMENTS. EVERY TYPE OF INTRAMEDULLARY PIN AND INSTRUMENTS. THE ONE AND ONLY BROWN ELECTRO-DERMATONE, accuracy, simplicity, perfect grafts every time without glue, suction cups, tape or other accessories. A new hand drill which will prove our craftsmanship. Also on display will be Woodruff Cut Pilot Point Bone Screws, Osteotomes, Gauges, Threaded Wires and Pins, Shiffrin Wire Twister, Luck Bone Saw and Blount Instruments. YOUR PROTECTION—LOOK FOR THE NAME ZIMMER, OUR TRADE MARK (Z).

WORLD MEDICAL ASSOCIATION

The World Medical Association is an organization whose membership is the medical associations of forty-three countries throughout the world. The United States member is the American Medical Association. It is a non-governmental body, and it is the voice of some 700,000 individual practicing physicians. Since its founding in 1947, it has met annually in General Assemblies in different cities throughout the world. Its council of thirteen members holds annual meetings in world capitals between General Assemblies, and its working committees hold meetings whenever necessary to carry on assigned tasks. Its work is supported by dues and voluntary contributions, largely raised through the United States Committee whose membership consists of individuals in the medical profession and allied fields, associations, foundations and industries.

The general objective of the World Medical Association is "to assist all people of the world to attain the highest possible level of health." This objective is being accomplished by WMA through:

1. Promotion of closer ties among national medical associations, their physician members and allied professions and industry.

2. Maintenance and protection of the honor, ethics and interest of the medical and allied professions.

3. Study and reporting on professional problems.

4. Organization of an exchange of information on matters of interest to the medical and allied professions.

5. Presentation of the opinions of practicing physicians and those of allied professions to WHO and UNESCO and

6. Raising the standards of medical education, medical care, and health throughout the world.

7. Conducting surveys and studies on medical educational standards, geographical distribution of physicians and members of allied professions, statistics on disease incidence, availability of antibiotics and scarce pharmaceuticals, et cetera.

8. Publishing of a quarterly bulletin in three languages for the dissemination of information of international interest and importance of the physicians and members.

Benefits the average practicing physician receives from membership on the United States Committee of WMA:

1. Contact with 700,000 doctors, forty-three national medical associations, and medical facilities in foreign lands.

2. A subscription to the *World Medical Association Bulletin*, issued quarterly, and copies of all available published studies.

3. A membership card entitling the holder to observer status at all World Medical Association Assemblies and a Federal income tax deduction on annual dues or contributions.

4. A share in defending the interest of practicing physicians and members of allied professions before international groups, such as UNESCO and WHO.

5. The satisfaction of sharing the advantages of our medical program with other lands, thus repaying a debt for the inspiration we have drawn from many countries through the generations.

Individual membership on the United States Committee of the World Medical Association is $10 annually, sponsoring membership $100 or more a year, and life membership is $500.

The World Health Organization (WHO) is an official branch of the United Nations, representing the governments of the world in the field of medicine, whereas the World Medical Association (WMA) represents the practicing physicians and national medical associations of the world. The latter is a non-governmental organization, and its funds are received from membership dues and voluntary contributions.

Members of the Michigan State Medical Society may join the World Medical Association's United States Committees for $10, the annual dues. The Secretariat of the Association is located in the Academy of Medicine, 2 East 103rd Street, New York 29, N. Y.

Annual Reports

ANNUAL REPORT OF THE COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION—1951-52

The Committee on Postgraduate Medical Education reports that the extramural program was held in the following centers in the year 1951-52: Alpena, Battle Creek, Bay City, Benton Harbor, Flint, Jackson, Lansing, Midland, Mt. Clemens, Muskegon, Saginaw, Traverse City in the lower peninsula; and at Escanaba, Houghton, Iron Mountain, Ironwood, Marquette, Menominee, and Sault Ste. Marie in the upper peninsula.

The subjects given on the *Fall Program* were:

Avoidable Obstetrical Deaths.
The Adrenals.
Selecting a Proper Antibiotic.
Cholesterol.
Convulsive Disorders.
Practical Aspects in the Medical Treatment of Heart Diseases.
Injuries to the Thoracic Cage.
Fractures of the Tibia.
The Use of ACTH and Cortisone in the Treatment of Blood Disorders.
Ulcerative Colitis.
Carcinoma of the Breast.

The subjects given on the *Spring Program* were:

Recent Advances in the Management of Diabetic Acidosis.
Common Foot Disorders and their Treatment.
The Treatment of the Compound Fracture.
Injuries to the Genito-Urinary Tract.
The Treatment of Fractured Ribs.
Physiology of the Male Hypogonadism—Diagnosis and Treatment.
Recognition and Treatment of the Complications of Blood Transfusion.
Medical Aspects of Atomic Warfare:
(a) Care of Casualties Surgical
(b) Care of Casualties Medical
Stab wounds of the Heart.
Lacerations of the Neck.
Injuries to the Rectum.
Principles in the Practical Use of Antibiotics.
Practical Approach to Venous Disorders.
Intestinal Obstruction.
Correctable Congenital Abnormalities in the Infant and Child.
Surgical Problems of the Newborn and Infant.
The Heart in Pregnancy—What does that Murmur mean?
Evaluation of Gastro-Intestinal Symptoms.
Management of the Severely Burned Patient.
Rheumatic Diseases.
Old Problems and New Methods in the Diagnosis and Treatment of Thyroid Disease.

Attendance 1951-52

Extramural Program	*Fall*	*Spring*	*Individual Physicians*
Alpena	14	15	19
Battle Creek	74	....	74
Bay City	40	38	57
Benton Harbor	....	40	40
Flint	54	50	86
Jackson	64	40	77
Lansing	47	50	73
Midland	26	....	26
Mt. Clemens	58	47	45
Muskegon	40	52	65
Saginaw	....	97	97
Traverse City	35	38	55
Upper Peninsula			
Escanaba	21	13	22
Houghton	13	18	21
Iron Mountain	19	19	19
Ironwood	20	15	23
Marquette	19	19	26
Menominee	28	....	28
Sault Ste. Marie	18	17	23
TOTAL	590	568	876

The following named physicians participated in the extramural postgraduate program during the year.

W. H. Beierwaltes, M.D.
Clifford Benson, M.D.
R. E. L. Berry, M.D.
Frank H. Bethell, M.D.
Abraham I. Braude, M.D.
Robert W. Buxton, M.D.
Duncan Cameron, M.D.
Muir Clapper, M.D.
Jerome W. Conn, M.D.
A. Jackson Day, M.D.
Russell N. DeJong, M.D.
C. Jackson France, M.D.
F. E. Greifenstein, M.D.
Sam Jacobson, M.D.
Louis Jaffe, M.D.
George H. Lowery, M.D.
Don W. McLean, M.D.
Wm. O. Maddock, Ph.D.
Rudolf J. Noer, M.D.
Sylvester J. O'Connor, M.D.
John Orebaugh, M.D.
Paul V. O'Rourke, M.D.
Eugene A. Osius, M.D.
Harold D. Priddle, M.D.
Henry K. Ransom, M.D.
Wm. D. Robinson, M.D.
Carlisle P. Schroeder, M.D.
Charles Sears, M.D.
Homer M. Smathers, M.D.
Harry A. Towsley, M.D.
Francis P. Walsh, M.D.
Charles F. Wilkinson, Jr., M.D.
Joseph A. Witter, M.D.

During the year, fourteen physicians were recommended to the Michigan Foundation for Medical and Health Education for Fellowship Certificates, and thirty-six physicians for Associate Fellowship Certificates in postgraduate medical education.

Registrations at the following meetings throughout the State have been received. Although requests for attendance reports on all these activities have been sent to those in charge, we have received reports only from the following:

St. Clair County Medical Society. June 5, 1951. Port Huron	77
AMA Annual Session. June 10-14, 1951. Atlantic City	229
Upper Peninsula Medical Society. June 22-23, 1951. Marquette	100
Coller-Penberthy Conference. July 26-27, 1951. Traverse City	122
Michigan State Medical Society. Sept. 26-28, 1951. Grand Rapids	1,480
Mt. Carmel Mercy Hospital Clinic Day. January 30, 1952. Detroit	437
Jackson Clinic Day. March 3, 1952. Jackson	91
Michigan Clinical Institute. March 12-14, 1952. Detroit	1,325
Genesee County Medical Society. Cancer Day. April 9, 1952. Flint	243
TOTAL	4,104

Intramural Activities

The postgraduate courses listed below were given at the University of Michigan Medical School with the following attendance:

Allergy	6
Anatomy	68
Basic Sciences	22
Clinical Exercises for Practitioners	25
Clinical Internal Medicine	58
Clinical Neurology	10
Diagnostic Methods. Clinical and Laboratory Interpretation	6
Diagnostic Roentgenology	24
Diseases of the Blood and Blood-Forming Organs	15
Diseases of the Gastro-Intestinal Tract	8
Diseases of the Heart	18
Electrocardiographic Diagnosis	53
Foreign Physicians	20
Interns, Assistant Residents, and Residents	283
Metabolism and Endocrinology	22
Miscellaneous	6
Obstetrics and Gynecology	49
Ophthalmology	116
Pediatrics	15
Recent Advances in Therapeutics	36
Rheumatic Diseases	7
TOTAL	867

The Committee held one meeting during the year which was well attended by the Committee members. At this meeting on December 6 a review of interest in the educational program was given and suggestions made for increasing attendance in all the teaching centers. A request was received from the Saginaw Veterans Hospital for a postgraduate program and the Committee asked that contact for such co-operation be made with the Saginaw County Medical Society and the District Councilor. The request for re-establishment of a teaching center in Berrien County was received favorably, and a postgraduate meeting was held in Benton Harbor in May, 1952. After discussion of subject material and teaching centers, Drs. Cummings and Sheldon were asked to prepare and submit to the whole committee the suggested program for the 1952 spring courses.

Dr. Cummings discussed the advisability of a survey to determine the interest in and results of postgraduate education, and the Committee agreed that a questionnaire be sent to all members of the Michigan State Medical Society. This survey was made for the year 1951 and the results are as follows:

Total number of questionnaires sent out	5,125	
Total number of questionnaires returned	2,089	
Attendance on		
1. Hospital Staff Meetings	1,871	physicians
2. County Medical Society Meetings	1,653	"
3. State Society Meeting	1,094	"
4. Michigan Postgraduate Clinical Institute	744	"
5. Postgraduate Programs at Extramural Centers in State	383	"
6. Postgraduate Meetings and Clinic Days in State		
(a) Cities list	489	"
(b) Others	83	"
7. Intramural Courses at Wayne University and University of Michigan	288	"
8. American Medical Association meeting	196	"
9. Courses for Specialists or General Practitioners.		
(a) In State	292	"
(b) Out of State	427	"
10. Meetings not listed on questionnaire.		
(a) In State	484	"
(b) Out of State	527	"

Further study of the questionnaires on the basis of the number of activities which each physician attended gave the following findings:

Maximum number of Activities listed on Questionnaire: *Ten*	
Number of physicians attending	
One activity	41
Two activities	139
Three activities	405
Four activities	564
Five activities	419
Six activities	264
Seven activities	112
Eight activities	51
Nine activities	9
Ten activities	3
Number of physicians attending no meetings because of retirement, service in the Armed Forces, illness, et cetera	82

Although further studies and analyses are necessary before conclusions can be drawn from this survey, it is apparent that the great majority of practicing physicians in Michigan are attending from one to ten medical activities each year. This is most encouraging and reflects the result of the State Society's work in postgraduate medical education during the past 25 years. The great expansion and development of local medical meetings, especially in the hospitals, and the large attendance upon annual clinical institutes and conferences held in our larger centers demonstrate the continuing interest of Michigan physicians in the progress of medicine. When the analysis of this survey has been completed, a report will be presented to the Society through THE JOURNAL.

* * *

It is hardly necessary to state that the four integrated agencies working in the Michigan State Medical Society program of postgraduate medical education have continued their interest and support to the work. This has made for a very successful year. The Committee is most grateful to the teachers who have given of their time to travel to the various centers in the State for the purpose of keeping the physicians who attend these meetings informed as to newer methods in diagnosis and treatment of disease. Great credit for continuing interest in postgraduate medical education must be given to the physicians in local hospitals who plan, conduct and take part in staff activities as well as to those who arrange local annual clinics and conferences and provide such outstanding authorities to address these meetings. Too much praise cannot be given to the officers of the Society for maintaining the high standards of programs and speakers at the Annual Michigan State Medical Society meeting and the Michigan Clinical Institute. Also, much credit must be given to the busy practitioners of medicine in both the general and special fields for their continuing interest in medical education in Michigan.

Wayne University College of Medicine
Postgraduate Medical Education

Courses	Number in Class by Quarters 1st (Sept.-Dec.) 1951	2nd (Dec.-Mar.) 1951-52	3rd (Mar.-June) 1952
Surgical Anatomy (Two quarters)		14	14
Regional Anatomy—			
Head & Neck			2
Thorax, Abdomen & Pelvis			18
Back and Extremities			6
Seminar in Physiological Chemistry	2	2	2
Recent Developments in Pharmacology & Therapeutics	18		
Blood (Two quarters)		2	2
Beginning Hematology	5		
Pathology of Ear, Nose & Throat		5	
Pathology of Bone & Joint Diseases		8	
Advanced Hematology		5	
Neuropathology			10
Seminar in Dermatology	6	4	4
Dermopathology Seminar	2	2	2
Superficial Mycoses	2		
Deep Mycoses		2	
Medical Conference	5		4
Electrocardiography (Three quarters)	30	30	30
Hematology Clinic	4	2	
Clinical Hematology	9	2	
Surgery Seminar	6	4	6
Obstetrics	10		5
Ophthalmic Surgery		1	
Cancer Detection	1	2	2
Gastroenterology		2	2
Medical X-Ray Conference		2	2

It has been a privilege for the Committee to serve the Michigan State Medical Society and the physicians of the State. The activities and programs have been far from perfect and it has been the policy of the Committee to establish no hard and fixed rules in conducting its work. Consequently, suggestions from the physicians of the State, from the officers of the Society, and from other Committees have been most welcome. It is the hope of the Committee that the members of the Michigan State Medical Society will feel free to make suggestions and recommendations to the Committee for the improvement of this program.

Respectfully submitted,
H. H. CUMMINGS, M.D., *Chairman*
E. I. CARR, M.D., *Vice Chairman*
C. E. BADGLEY, M.D.
B. R. CORBUS, M.D.
A. C. FURSTENBERG, M.D.
L. J. GARIEPY, M.D.
J. R. HEIDENREICH, M.D.
D. H. KAUMP, M.D.
ALFRED LABINE, M.D.
J. M. ROBB, M.D.
G. H. SCOTT, Ph.D.
J. M. SHELDON, M.D.
E. F. SLADEK, M.D.
E. D. SPALDING, M.D.
F. A. WEISER, M.D.

ANNUAL REPORT OF HOSPITAL RELATIONS COMMITTEE—1951-52

This Committee was appointed as a liaison Committee of the Michigan State Medical Society to confer with a similar committee of the Michigan Hospital Association to consider procedures and problems of mutual interest to both organizations. There were two meetings, the first of the committee itself, the second a joint meeting with the committee of the Michigan Hospital Association.

At the first meeting a proposed autopsy bill was studied and an autopsy bill for the State of Michigan was written. A hospital licensing bill prepared by A. E. Heustis, M.D., State Health Commissioner, at the request of Governor Williams was considered. A Michigan Hospital Association resolution asking that the Commission on Financing of Hospital Care, a project of the American Hospital Association, make one or more of its studies in Michigan was discussed with a view to support by the MSMS. Action on the hospital licensing bill and the resolution of the Michigan Hospital Association was postponed until the joint meeting with the Liaison Committee of that Association.

At the joint meeting with the Michigan Hospital Association it was reported that the autopsy and hospital licensing bills had died in Committee in the Legislature and that lack of finances would prevent the Commission on Financing of Hospital Care from making any of its studies in Michigan.

A recommendation by the MSMS Tuberculosis Control Committee that chest x-rays be taken on every hospital patient was approved in principle.

The Hospital Cost Commission Bill was approved with amendments drafted by several of the hospital trustees and a reimbursable cost formula. The Practical Nurse Bill was approved with the proviso that Amendment 5 be deleted.

The so-called "privilege tax" bills, which would impose a tax on Blue Cross-Blue Shield were discussed but no action taken. It was reported to the two Committees that so many requests for surveys by means of questionnaires from the Federal Security Agency were being sent to individual hospitals that the Trustees of the Michigan Hospital Association require that such questionnaires be sent to them for approval prior to their execution.

It is hoped that the liaison committees may be of service to and further accord between MSMS and MHA.

Respectfully submitted,

L. W. Hull, M.D., *Chairman*
A. H. Kretchmar, M.D.
J. W. Logie, M.D.
W. S. Reveno, M.D.
C. E. Umphrey, M.D.
Ralph Wadley, M.D.

ANNUAL REPORT OF THE SCIENTIFIC RADIO COMMITTEE—1951-52

During the year 1951-52, a total of forty-six scientific radio programs were prepared and presented by members of the Michigan State Medical Society and of the faculties of the University of Michigan Medical School and Wayne University College of Medicine. These programs have been broadcast over thirteen stations in Michigan and three out-of-state stations.

Topics for these talks have included the fields of pediatrics, psychiatry, surgery, cancer, dermatology, allergy, obstetrics and gynecology, internal medicine, endocrinology and metabolism; in addition, there were talks given on hospital care and voluntary hospital insurance. Thoroughly scientific, the talks are given in simple terms understandable to the layman. Emphasis is given to the "ordinary" medical problems which anyone might someday encounter.

The Committee feels that the programs help to foster and extend the interest of the lay public in medical subjects and serve to provide health education to a fairly large group of people in the state. These programs have been on the air longer than any other University of Michigan series—evidence of their continuing popularity.

We should like very much to have a broader reception of these programs and hope that through the co-operation of county medical societies the programs may be carried by a larger number of stations.

We shall be very glad to have members of the State Society volunteer to aid us in this public service program, so that we may be assured of its successful continuation.

Respectfully submitted,

John M. Sheldon, M.D., *Chairman*

C. B. Beeman, M.D.
F. J. Kemp, M.D.
R. J. Noer, M.D.
K. L. Swift, M.D.
K. W. Toothaker, M.D.
E. C. Vonder Heide, M.D.

ANNUAL REPORT OF GERIATRICS COMMITTEE—1951-52

The Geriatrics Committee held two meetings this year with the majority of the members present each time. There was a good medical representation each day at the Michigan Conference on Aging which convened at Lansing, May 12-13, 1952. Members of the Geriatrics Committee and other physicians interested in any of the problems of aging expressed their opinions on the various propositions offered for discussion. This included the health group, which discussed facilities and health programs for mental and non-mental chronically ill; the economic status of older people in Michigan, employment practices and opportunity for older people; problems in education of older adults; and community planning for housing.

During July all the members of the Committee participated in the 5th Annual Conference on Aging held in Ann Arbor, under the auspices of the University of Michigan Institute for Human Adjustment, Department of Gerontology, Dr. Wilma Donahue, Director. All problems of housing and living arrangements were conclusively covered at this three day Conference.

The Subcommittee on Study Courses for Directors of Nursing Homes, directed by Dr. F. A. Weiser met and reported to the Geriatrics Committee at its last meeting. Plans are being formulated in conjunction with Dr. Donahue for the setting up of two to three-day institutes on a regional basis for directors and attendants in nursing homes. Consideration was also given to the establishment of a course for those persons wishing to make a career as nursing attendants.

Under the leadership of Dr. F. A. Swartz, plans are under way to devote one issue of The Journal of the Michigan State Medical Society entirely to subjects of interest in preventive geriatrics and gerontology.

The Committee hopes to co-operate in the establishment of a Health Pavilion at the Michigan State Fair next year. Diabetes detection and preventive Geriatrics will be stressed.

Under the Chairmanship of Dr. W. M. LeFevre, the Subcommittee on Diabetes Control reports there are forty-two Diabetic Detection Committees throughout the state. Through newspapers, radio talks, talks to service clubs and P.T.A., the program has progressed quite well. Six counties have given free urine tests and out of 9,800 tests made, seventy-six positive urines were discovered in persons not previously classed as having diabetes. Fifty of these were proved to be true diabetics.

Respectfully submitted,

A. Hazen Price, M.D., *Chairman*
F. A. Weiser, M.D., *Vice Chairman*
W. M. LeFevre, M.D., *2nd Vice Chairman*

R. M. Athay, M.D.
F. W. Baske, M.D.
J. R. Brink, M.D.
P. C. Gittens, M.D.
R. A. Johnson, M.D.
J. J. Lightbody, M.D.
Mark Marshall, M.D.
H. H. Riecker, M.D.
D. R. Smith, M.D.
F. C. Swartz, M.D.
G. C. Thosteson, M.D.
S. C. Wiersma, M.D.
W. J. Wilson, Jr., M.D.

ANNUAL REPORT OF THE MENTAL HYGIENE COMMITTEE—1951-52

The Mental Hygiene Committee of the Michigan State Medical Society has held five meetings during the past year. All but one of these meetings have been very well attended by members of the Committee.

A number of important problems were brought to the attention of the Committee for discussion during the year. A consideration of the use of carbon dioxide treatment was further discussed following the editorial in the MICHIGAN STATE MEDICAL JOURNAL, sponsored by the Committee last year. Two physicians took exception to this editorial and one of these appeared before the Committee to discuss this treatment and to demonstrate its use by motion pictures. No further action was considered necessary.

The Committee sponsored an editorial, which was written by a member of the Committee and published in THE JOURNAL of the State Medical Society, having to do with the Mental Health Program in Michigan. An expression of the need for more physicians on the Mental Health Commission was indicated, with a resolution that the President of our Society make such a recommendation to the Governor.

At the request of the President of the State Medical Society a program for the Department of Mental Health was discussed at length and a preliminary draft was prepared which was amended and approved by the Committee and forwarded to the Council for its approval, with the recommendation that it be presented to the Legislature for its consideration. This represented a very careful consideration of the problem of the mentally ill in Michigan and the best way to meet the problem. This was entitled, "Suggested Plan for the Department of Mental Health as presented by the Michigan State Medical Society."

In view of the difficulty expressed by members of the Legislature concerning the definition of a psychiatrist, the Committee attempted to formulate such a definition in a manner which would be acceptable to the Michigan Society of Neurology and Psychiatry, as well as to the Michigan State Medical Society. Such definition was formulated and forwarded to the Council for its acceptance in the hope that it would be made available to members of the Legislature. This was disapproved by the Council. Apparently the result of a misunderstanding and on rediscussion of it in Committee, it was moved that the recommendation be re-submitted to the Council. It was requested that the Council permit the attendance of the Chairman of our Committee and of Doctor Martin Hoffman (MSMS representative to the Special Legislative Committee) to explain to the Council the purpose of the re-submission of this matter.

Considerable discussion was had also concerning the problem of narcotic addiction. Reports from the Detroit Committee on Narcotic Addiction and of the State Board of Alcoholism were accepted at the last meeting of the Committee.

At the last meeting the Committee recommended to the Council that the State Society request the Governor and the Legislature to appoint a Commission to investigate and prepare standards regarding the teaching of mental hygiene in public schools. It was felt that this Commission should be constituted of at least two Doctors of Medicine, two educators, two lawyers, three clergymen, one Journalist, one member of the Parent-Teacher's Association and a member of the Juvenile Court. It seemed that this is an important step forward and it is hoped that this recommendation may be activated eventually.

Re-emphasis of the need for the Governor to keep in mind the appointment of two medical men, preferably psychiatrists, on the Commission of the Department of Mental Health was made.

The members of the Committee have expressed enthusiasm of its accomplishments during the past year and the hope that these activities have been of assistance to the State Medical Society. The Chairman particularly wishes to express his feeling of appreciation for the active participation and co-operation of the members of the Committee, and in particular to President Beck and Past President Umphrey for their attendance and counsel at some of the meetings of the Committee.

Respectfully submitted,
RAYMOND W. WAGGONER, M.D., *Chairman*
H. E. AUGUST, M.D.
C. D. BENSON, M.D.
I. C. BERLIEN, M.D.
F. P. CURRIER, M.D.
W. W. DICKERSON, M.D.
J. M. DORSEY, M.D.
G. C. FINK, M.D.
E. M. GATES, M.D.
T. J. HELDT, M.D.
L. E. HIMLER, M.D.
M. H. HOFFMAN, M.D.
C. G. JENNINGS, M.D.
R. F. KERNKAMP, M.D.
MORRIS MARKS, M.D.
F. O. MEISTER, M.D.
SIDNEY MILLER, M.D.
O. R. YODER, M.D.
H. A. LUCE, M.D., *Advisor*

ANNUAL REPORT OF CONTACT COMMITTEE WITH UNIVERSITY OF MICHIGAN PRESIDENT—1951-52

No problems have arisen during the year 1951-52 that required a meeting of this Committee.

Respectfully submitted,
E. I. CARR, M.D., *Chairman*
R. J. HUBBELL, M.D.
L. FERNALD FOSTER, M.D.

ANNUAL REPORT OF LIAISON COMMITTEE WITH MICHIGAN MEDICAL SERVICE—1951-52

This newly formed committee met on April 16, 1952, with the personnel of the Professional Relations Department of Michigan Medical Service. The doctor members will serve as counselors to the area field representatives in the effort to increase mutual understanding, reduce problems and aid in adjusting specific situations. It is the intent of all members of the committee that the orderly expansion of this service program has close liaison with its participating physicians.

Respectfully submitted,
WILLIAM BROMME, M.D., *Chairman*
R. S. BREAKEY, M.D.
L. C. CARPENTER, M.D.
B. M. HARRIS, M.D.
W. H. HURON, M.D.
G. W. SLAGLE, M.D.
J. M. WELLMAN, M.D.
D. B. WILEY, M.D.

ANNUAL REPORT OF MEDICAL PROCUREMENT ADVISORY COMMITTEE—1951-52

The Medical Procurement Advisory Committee held no meetings during the past year. No business was referred to this Committee from the Executive Office.

Respectfully submitted,
C. I. OWEN, M.D., *Chairman*
M. J. CAPRON, M.D.
C. H. FRANTZ, M.D.
W. H. HURON, M.D.
E. C. MILLER, M.D.
G. C. PENBERTHY, M.D.
J. R. RODGER, M.D.
H. H. STRYKER, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE TO NATIONAL FOUNDATION FOR INFANTILE PARALYSIS—1951-52

Inasmuch as the Advisory Committee to the National Foundation for Infantile Paralysis has had no meetings during the year 1951-1952 there is nothing further to report.

Respectfully submitted,
M. F. Osterlin, M.D., *Chairman*
E. R. Elzinga, M.D.
E. E. Martmer, M.D.
N. R. Moore, M.D.
F. H. Purcell, M.D.
F. P. Walsh, M.D.
J. E. Webber, M.D.

ANNUAL REPORT OF MEDIATION COMMITTEE—1951-52

There have been no meetings held of the Mediation Committee as no incidents of importance have been brought to my attention which have required a meeting. The various county mediation committees have been functioning very well and no problems have been referred to the state committee.

Respectfully submitted,
W. Z. Rundles, M.D., *Chairman*
L. R. Leader, M.D.
E. W. Meredith, M.D.
E. T. Morden, M.D.
J. R. Ralyea, M.D.
R. W. Teed, M.D.
E. H. Terwilliger, M.D.
C. F. Vale, M.D.
Ralph Wadley, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE TO WOMAN'S AUXILIARY—1951-52

No major problems have arisen, as yet, that have required the services of this committee.

We have offered our services and the Chairman has consulted frequently with Mrs. Robert Breakey, the efficient President of the Woman's Auxiliary, on minor matters.

The Chairman suggests that a joint yearly meeting be held with the Public Relations Committee to facilitate the efforts of the Auxiliary.

We heartily commend the efforts of the Auxiliary and the splendid work that they accomplish.

Respectfully submitted,
J. S. Rozan, M.D., *Chairman*
A. B. Aldrich, M.D.
F. C. Brace, M.D.
W. G. MacKersie, M.D.
C. O. Willits, M.D.

ANNUAL REPORT OF THE SPECIAL COMMITTEE TO MEET WITH MICHIGAN DEPARTMENT OF SOCIAL WELFARE—1951-52

As stated in our report of one year ago, your committee was made an integral part of a permanent Advisory Committee appointed by the State Welfare Commission and, as such, met in September and December, 1951, and on May 2, 1952.

The bulk of these meetings were devoted to developing plans for providing Medical care for recipients of categorical assistance in selected counties as pilot studies. As reported to The Council in January, 1952, plans were completed, Calhoun County Medical Society had voted to co-operate in this study, and Michigan Medical Service offered us their help in order to obtain actuarial information. All of this information was submitted to the Federal Security Agency and after much delay we were informed on April 15, 1952, that they could not approve such a plan, hence the matching Federal funds would not be forthcoming if we attempted same. The committee voted to table the plan for the time being.

Many other problems were discussed, chief of which were those dealing with the new Social Security Amendments affecting eye examinations for the Aid to the Blind, the extended use of the local Medical Consultants by the Department, and the formulation of a liberalized definition for Aid to the Disabled.

The Michigan Department of Social Welfare has extended thanks to each member of the Advisory Committee and desires that such a committee be a permanent policy. As during the first year, our relations with the Department have been most cordial and mutually beneficial.

Respectfully submitted,
G. W. Slagle, M.D., *Chairman*
Wilfrid Haughey, M.D.
R. J. Hubbell, M.D.
L. G. Christian, M.D., *Ex-Officio Representing Welfare Commission*

ANNUAL REPORT OF SUBCOMMITTEE FOR TRAINING PROGRAMS FOR MEDICAL AND PARA-MEDICAL PERSONNEL (SUBCOMMITTEE OF EMERGENCY MEDICAL SERVICE COMMITTEE)—1951-52

Public and professional apathy was recognized as perhaps the greatest problem in the educational and training program. Since many physicians, e.g., dermatologists, would be called upon to do things with which they were unfamiliar, a basic training program for all, on atomic casualty treatment was agreed upon. Dentists and nurses should have similar training. The former would be given particular information on anesthesia and shock.

In the case of nurses, education to enable them to use more initiative in the administration of morphine, transfusions, and other parenteral fluids is to be stressed. Nonprofessional workers assigned to medical units will have a modified first aid course such as given by the Red Cross, but limited to matters relevant to emergency medical care in the event of disaster. Co-operation between the office of civil defense and the medical society on state and county levels is essential.

It was urged that the Michigan Hospital Association be invited to participate in the Emergency Medical Service Committee.

Respectfully submitted,
Louis Jaffe, M.D., *Chairman*
A. G. Baker, M.D.
R. F. Hague, M.D.
D. H. Kaump, M.D.
J. A. Witter, M.D.

ANNUAL REPORT OF COMMITTEE ON STANDARDIZED MEDICAL CARE FOR CASUALTIES IN ATTACK (SUBCOMMITTEE OF EMERGENCY MEDICAL SERVICE COMMITTEE)—1951-52

It was soon realized that a policy of uniform medical care was desirable both from the standpoint of training purposes and procurement of suitable supplies in quantity for use in the care of casualties. Furthermore since, in the event of disaster, the state will function as a unit it is essential that medical care throughout the state be integrated. Many adequate procedures for the care of burns, fractures, etc., were evaluated. Since the Wayne County Medical Society was well along in formulating uniform medical procedures, it was felt that the state as a whole adopt these procedures, with whatever minor modifications might later be necessary.

Respectfully submitted,
Louis Jaffe, M.D., *Chairman*
R. F. Hague, M.D.
D. H. Kaump, M.D.

ANNUAL REPORT OF LIAISON COMMITTEE WITH MICHIGAN VETERANS' ORGANIZATIONS —1951-52

This newly formed committee held its first meeting on February 7, 1952. Service representatives from the Veterans of Foreign Wars, American Legion, Disabled American Veterans and Amvets were present. It was mutually agreed that there has been need for such a meeting for a long time in view of the increasing group of the public which has seen military service, the widely recognized value of the Michigan Home Town Care Program for Veterans which utilizes Michigan Medical Service as an intermediary, and other mutual problems.

Respectfully submitted,
WILLIAM BROMME, M.D., *Chairman*
R. H. BAKER, M.D.
G. W. SLAGLE, M.D.
MR. J. W. CASTELLUCCI

ANNUAL REPORT OF COMMITTEE ON BLOOD BANKS—1951-52

The Blood Bank Committee has held no formal meetings during the year. Members of the Committee have co-operated with other Committees in problems of mutual interest. Such examples might include work with the Emergency Medical Service Committee of the Michigan State Medical Society, and the Blood Bank Committee of the Wayne County Medical Society.

It might be advantageous for The Council to incorporate the Blood Bank Committee as a subcommittee of the Emergency Medical Service Committee.

Respectfully submitted,
D. H. KAUMP, M.D., *Chairman*
W. B. COOKSEY, M.D.
R. H. HOLMES, M.D.
A. A. HUMPHREY, M.D.
H. R. PRENTICE, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE TO THE CANCER FOUNDATION OF THE MICHIGAN FEDERATION OF BUSINESS AND PROFESSIONAL WOMEN'S CLUBS—1951-52

No problems have arisen during the year 1951-52 that required a meeting of this Committee.

Respectfully submitted,
E. I. CARR, M.D., *Chairman*
C. H. KEENE, M.D.
H. M. NELSON, M.D.

ANNUAL REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH—1951-52

The third "Michigan Industrial Health Day" was held on May 7, 1952, at Flint. The program was arranged by a committee from the Michigan Association of Industrial Physicians and Surgeons and co-sponsored by the Michigan State Medical Society's Committee on Industrial Health, the American College of Surgeons, the University of Michigan, Wayne University and the Michigan State Department of Health.

The Clinical Program was presented at the Merliss Brown Auditorium of Hurley Hospital. The largest registration of any of the previous Industrial Health Days was experienced. A reception and banquet sponsored by Flint industrial groups followed the clinical program. Guests included members of the Genesee County Medical Society and representatives of the American Medical Society's Committee on Industrial Health, the Industrial Medical Association and the University of Michigan's Institute of Industrial Health. A. C. Ivy, M.D., Professor of Physiology, University of Illinois, gave the banquet address.

During 1951-1952, the individual activities of the Committee on Industrial Health rose to new heights. Members of your committee served as President of the Industrial Medical Association, President of the Michigan Association of Industrial Physicians and Surgeons, Vice-Chairman of the Committee of State Chairmen on Industrial Health and on the Program Committee for the annual Industrial Health Day.

Committee members attended the Twelfth Annual Congress on Industrial Health at Pittsburgh in January and the Industrial Physicians Association meeting in Cincinnati in April.

Objectives of the Committee on Industrial Health continue as previously outlined: (1) Encourage the introduction of subjects on industrial medicine in the various county medical societies' programs. (2) Arrange "inplant" meetings—visits to industrial medical departments —outlining health maintenance programs conducted by industrial physicians. (3) Co-operate with the Council on Industrial Health of the A.M.A. in interesting physicians in general practice in the field of industrial health. (4) Review proposed state legislation affecting industrial medical practice. (5) To aid in the establishment of a better understanding of the problems which mutually affect the industrial medical director and the physician in private practice.

Respectfully submitted,
MAX R. BURNELL, M.D., *Chairman*
W. P. CHESTER, M.D.
E. B. CUDNEY, M.D.
W. A. DAWSON, M.D.
E. A. IRVIN, M.D.
O. J. JOHNSON, M.D.
V. S. LAURIN, M.D.
E. F. LUTZ, M.D.
OTTO PRESTON, M.D.
N. W. SCHOLLE, M.D.
H. T. SETHNEY, M.D.
M. W. SHELLMAN, M.D.
J. L. ZEMENS, M.D.
C. D. SELBY, M.D., *Advisor*

ANNUAL REPORT OF COMMITTEE ON PLANNING AND ORGANIZATION (SUBCOMMITTEE OF EMERGENCY MEDICAL SERVICE COMMITTEE)—1951-52

The subcommittee held one meeting in February, 1952. At the meeting a considerable amount of discussion was applied to the problem of statewide medical civil defense plan so that all members of the Michigan State Medical Society could be integrated into this important responsibility. As a result of detailed deliberation the subcommittee prepared recommendations which were submitted in the form of resolutions to the Committee on Emergency Medical Service. These were approved by the Committee and subsequently by the Council of the Society. It should be stated that present at the subcommittee meeting were representatives of the Michigan State Health Department and of the Michigan State Office of Civil Defense.

Further action taken at the meeting was the decision that study should be given to the problem of chemical and bacteriological warfare. Dr. Schmidt of Jackson was requested to do the preliminary investigation on the subject for submission to the subcommittee at a future meeting. He has completed this task in a most commendable manner and it proposed that the subcommittee meet shortly to consider this topic.

The chairman recommends that the subcommittee as well as the full committee concern themselves with the problem of a uniform state medical civil defense plan. Any planning which involves participation by members of the Michigan State Medical Society and its component county medical societies should be developed by responsible agencies in the fullest co-operation with the

Society. It is felt that the Society should assume a leading part in the development of such planning.

Respectfully submitted,

M. L. LICHTER, M.D., *Chairman*
C. P. ANDERSON, M.D.
A. G. BAKER, M.D.
G. J. CURRY, M.D.
R. F. HAGUE, M.D.
J. A. RAMSEY, M.D.
T. E. SCHMIDT, M.D.

ANNUAL REPORT OF COMMITTEE ON TUBERCULOSIS CONTROL—1951-52

The principal items brought up for discussion before the Committee on Tuberculosis Control were as follows:

1. *Management of Recalcitrant Tuberculosis Patients.*—This was discussed by State Health Commissioner A. E. Heustis, M.D., who gave the Attorney General's opinion that the present law is not adequate to cope with this problem, as follows: "Elbern Parsons, Assistant Attorney General, advised me on January 27, that the present statute does not permit the use of the tuberculosis units of state mental or penal institutions for the confinement of the committed patient who leaves against advice. Mr. Parsons made reference to A.G.O. 0-4093 date 11/6/45 and stated that the same opinion would apply to mental institutions and that so far as he knew there had been no change in the statutes since that time which would alter the situation.

"Mr. Parsons was asked to review the penalty provision in the proposed new statute. He feels that it would be best if Chapter VII, Section 1 were to be amended to read as follows:

" 'Section 1. Any person committeed to any approved hospital or institution established for the care and treatment of persons suffering from tuberculosis as in Chapter III, Section 7, hereinbefore provided, who shall willfully escape from or leave such hospital or institution prior to the termination of such commitment by the medical director of the hospital or institution, shall be guilty of a high misdemeanor and shall be punished by imprisonment for not more than one year IN THE TUBERCULOSIS UNIT OR HOSPITAL OF A STATE PRISON or a fine not to exceed $1,000 or both.' "

The matter was discussed by Chairman Towey, Drs. Egle, Stringer, and Heustis, during which the difference between commitment and quarantines was brought out.

MOTION: That the Tuberculosis Control Committee approve the inclusion in the proposed codification of the tuberculosis laws of the State of Michigan the recommendation of the Attorney General and of the State Health Commissioner that patients violating their commitment to TB hospitals shall be guilty of a misdemeanor. Carried.

2. *Routine General Admission X-Rays.*—The State Health Commissioner stated that there are 18 photo roentgen units belonging to the State Department of Health now being used in various hospitals throughout the state. There is a wide variance as regards their use, from 2.1 per cent up to 91.6 per cent. There is also considerable variance as regards the hospital charge for this routine x-raying. In two hospitals there is no charge but the others charge ranging up to a maximum of $2.00.

MOTION: That the Tuberculosis Control Committee recommend to the Hospital Relations Committee that in every possible case on admission a chest x-ray should be taken. Also it was suggested that the staffs of the hospitals which have these photo roentgen units on loan from the State Department of Health be asked if they wish to continue use of the instrument or to give the unit to another hospital.

3. *The need for more tuberculosis beds in Wayne County* to take care of the great needs in this area was discussed together with the need for a better state subsidy to counties now hospitalizing their tuberculosis patients there.

4. *A proposed revision of the Michigan Tuberculosis Laws* was discussed at some length.

MOTION: That the TB Control Committee approve in principle the proposed recodification of Michigan's TB laws, as proposed by the State Health Commissioner, with the exception that certain features require further study prior to active approval or disapproval.

Respectfully submitted,

J. W. TOWEY, M.D., *Chairman*
J. L. EGLE, M.D.
J. F. FAILING, M.D.
CAMERON HAIGHT, M.D.
A. E. HEUSTIS, M.D.
V. C. JOHNSON, M.D.
C. E. LEMMON, M.D.
G. T. MCKEAN, M.D.
C. P. MEHAS, M.D.
C. J. STRINGER, M.D.

ANNUAL REPORT OF COMMITTEE ON EMERGENCY MEDICAL SERVICE—1951-52

Since the last report, this Committee has met on the following dates: January 16, 1952, and April 2, 1952. In addition the Sub-Committee on Planning and Organization of Emergency Medical Service met on February 2, 1952. Also the Sub-Committee on Training Programs for Medical and Paramedical Personnel of the Emergency Medical Service met on April 30, 1952. Further, the Committee on Standardized Medical Care for Casualties in Attack met and advised that the Emergency Medical Service Committee recommend to The Council of the Michigan State Medical Society the acceptance of the papers as published by the Wayne County Medical Society in the Michigan State Medical Society Journal of March, 1952, as standard operating procedures for emergency medical service in case of an attack. It was also recommended that these be bound in a pocket size book for distribution to the medical profession of the State of Michigan.

The Chairman of the Committee has attended two meetings, one in St. Louis, the First Regional Conference on June 10, 1951, and the Second Medical Mid-west Civil Defense Conference at Chicago, November 9-10, 1951. At this meeting there were three other members of the Emergency Medical Service Committee present. He has also attended meetings of the Technical Committee on Medical and Health Services under the Chairmanship of Albert E. Heustis, M.D., on March 16, 1951, February 7, 1952, and April 10, 1952.

From the above meetings and the information obtained, the following observations can be made:

Civil Defense plans are in various stages of development in a large number of the key cities of Michigan. They would proceed much faster and better if there was not as much apathy among the civic, fraternal and other leaders. This apathy has been transferred to the legislative bodies at the level of cities, counties and state.

The medical profession of the State as a whole is well aware of the importance of civil defense. Physicians in every community hold important positions on the civil defense committees. They have been addressed in the past year by Dr. Stafford L. Warren and Dr. Norvin C. Kiefer as well as other physicians whose names are nationally known in this field.

An all-over State Medical Plan is being developed by Dr. Arthur G. Baker who represents Dr. Heustis on the staff of Brig. General L. J. Maitland assisted by Dr. M. L. Lichter and other members of this Committee. The liaison with the two medical schools of the state has

been accomplished by the appointment of the two deans to the committee for their expert advice. Lectures are being given on civil defense, and the recruiting of personnel both professional and lay is being encouraged.

The Wayne County Medical Civil Defense Committee has enlisted the women of the Woman's Auxiliary to the Wayne County Medical Society and have notarized their loyalty oath. Over 1,100,000 people in Michigan have been blood typed and have received their tags.

Our agenda for 1952-1953 is as follows:

Develop a State Medical Plan into a functioning plan.

Complete our Standard Operating Procedures and if the money is obtainable publish them, in pocket-size book form.

Continue recruiting Professional and non-professional personnel, organize and train them, establish the role of medical students.

Plan Postgraduate training programs for the physicians.

Lecture to the lay organizations and recruit their co-operation.

Encourage the continued co-operation and participation of hospital and hospital staffs.

Respectfully submitted,

W. H. GORDON, M.D., *Chairman*
W. H. ALEXANDER, M.D.
C. P. ANDERSON, M.D.
A. G. BAKER, M.D.
A. C. FURSTENBURG, M.D.
R. F. HAGUE, M.D.
S. W. HARTWELL, M.D.
LOUIS JAFFE, M.D.
D. H. KAUMP, M.D.
M. L. LICHTER, M.D.
J. A. RAMSEY, M.D.
G. H. SCOTT, Ph.D.

ANNUAL REPORT OF COMMITTEE TO CO-OPERATE WITH MICHIGAN HEALTH COUNCIL RE PERIODIC HEALTH APPRAISAL—1951-52

This Committee has met with the committee of the Michigan Health Council and with a special subcommittee to help in developing a program of periodic health appraisal. It is feared that the educational programs of the various voluntary health agencies, however well conceived, have the disadvantage of directing attention to a single organ or system or to a particular type of disease. A periodic, comprehensive general physical examination and health appraisal are to be preferred. Many voluntary health agencies are in accord with this. The Michigan Health Council, with the co-operation of the Michigan State Medical Society, is providing the leadership which is needed to present this idea to the profession and to the people. It is an essential part of the Know Yourself section of the Formula for Freedom. It is a long-term, continuing program. It offers better health and better medical care to the people through closer contact with their physicians, the application of preventive measures, and the detection of unsuspected disease and its treatment.

It is agreed that the first step is to acquaint the profession with the program, the need for it, the type of examination which is needed and which is practical, and the benefits to be expected. It is hoped that the program of postgraduate medical education may include this subject, and that it may be presented at meetings of county medical societies, hospital staffs and various other medical groups, and that articles will be prepared for the various medical journals and bulletins which reach the profession of this state.

The second step is to acquaint the public with this program, the need for it, the type of examination to be carried out and the benefits to be expected from it. Emphasis is on the family physician. A questionnaire has been devised for presentation to the general public, designed to stimulate interest in the periodic health appraisal.

The committee should be continued because this is a long-term, continuing program.

Respectfully submitted,

J. S. DETAR, M.D., *Chairman*
P. S. BARKER, M.D.
J. G. BIELAWSKI, M.D.
W. B. COOKSEY, M.D.
D. C. ENSIGN, M.D.
W. A. IRVIN, M.D.
W. M. LEFEVRE, M.D.
J. J. LIGHTBODY, M.D.
E. F. LUTZ, M.D.
O. T. MALLERY, M.D.
H. M. POLLARD, M.D.
H. W. PORTER, M.D.
F. L. RECTOR, M.D.
W. S. REVENO, M.D.
R. F. SALOT, M.D.
E. F. SLADEK, M.D.

ANNUAL REPORT OF COMMITTEE ON STUDY OF MEDICAL PRACTICE ACT—1951-1952

No meetings of this Committee or the Joint Committee with the Michigan State Board of Registration in Medicine were held.

Respectfully submitted,

W. B. HARM, M.D., *Chairman*
L. A. DROLETT, M.D.
MR. J. JOSEPH HERBERT
J. E. LIVESAY, M.D.
J. D. MILLER, M.D.

ANNUAL REPORT OF COMMITTEE ON RHEUMATIC FEVER CONTROL—1951-52

This Committee has had five meetings and contemplates one more. In addition to the routine business of the Committee which consists of analyzing in detail the reports of the various diagnostic centers and studying a progress report of the co-ordinator, Dr. Leon DeVel, the Committee has passed upon several desk reference cards which in turn have been forwarded to the membership of the State Society. These cards have summarized important features in diagnosis of rheumatic fever and rheumatic heart disease, management, and treatment as well as one card which takes up exclusively congenital heart lesions with a short résumé of surgical procedures in congenital and acquired heart lesions.

The standard forms used by the Rheumatic Fever Diagnotic and Consultation Centers have been completely revised and distributed.

A Cambridge electrocardiograph-stethograph has been purchased by the Committee for the use of the various Rheumatic Fever Centers, under the supervision of the State Committee.

Four new Rheumatic Fever Diagnostic and Consultation Centers have been activated: the St. Joseph-Benton Harbor Rheumatic Fever Center, sponsored by the Berrien County Medical Society, to serve Berrien, Cass and part of Van Buren counties; the Sault Ste. Marie Rheumatic Fever Center, sponsored by the Chippewa-Mackinac County Medical Society, to serve Chippewa, Mackinac and Luce Counties; the Northern Michigan Rheumatic Fever Center at Petoskey, sponsored by the Northern Michigan Medical Society, to serve Emmet, Charlevoix, Cheboygan, Antrim and Otsego counties; the Royal Oak Rheumatic Fever Center, sponsored by the Oakland County Medical Society, to serve southern Oakland county and adjacent areas of Macomb and Wayne counties. This brings the number of organized Rheumatic Fever Centers under the Rheumatic Fever Control Program of the Michigan State Medical Society to thirty: fifteen in Wayne county, fifteen out-state.

The situation in Wayne County has clarified considerably after several meetings with the officers of the Wayne County Medical Society and members of the Wayne County Rheumatic Fever Control Committee.

The present plan in Wayne County calls for continuation of the Rheumatic Fever Diagnostic Centers in those hospitals which do not already have an out-patient program. In those hospitals and teaching institutions where an out-patient program is already in operation the statistical information from this source will be available to the State Committee and the present plans call for its incorporation in the overall state picture.

The trial program in Pontiac under the direction of Dr. Smith where part of the expense for the clinic visit was defrayed by a special grant from the State Committee has been in operation for over a year. It's the feeling of Dr. Smith and shared by the State Committee that this program has worked out to the very marked advantage of the local area and the State Committee feels that additional monies should be made available for the extension of the plan in other areas. Parenthetically, some of the officers of the Michigan Heart Association feel very favorably toward this plan.

Four Postgraduate Fellowships for the study of rheumatic fever and rheumatic heart disease have been awarded by the Committee for 1952, on the basis of the personal merits of the applicants and in relation to the overall needs throughout the State. The Committee approved the Comprehensive Course in Rheumatic Fever given at St. Francis Sanatorium, Roslyn, Long Island, May 19 to May 31. Recipients of the 1952 Fellowships are: Anthony Cefai, M.D., Pontiac; John D. Littig, M.D., Kalamazoo; S. T. Harris, M.D.; Ypsilanti; David P. Gage, M.D., Saginaw. Two additional Fellowships have been made available for 1952 and the Committee hopes to fill these with postgraduate opportunities elsewhere.

The Committee has requested a liaison appointment with the Child Welfare Committee of the Michigan State Medical Society to study the advisability of more detailed school health examinations as a demonstration project not only for its own merits but in an attempt to evaluate the amount of rheumatic fever and rheumatic heart disease among school children. This request has been granted by the Council and a new Committee is charged with this project.

Because of pressure of other projects, the Michigan Society for Crippled Children and Adults, Inc., has withdrawn its support from this Committee's activities and Mr. Angove has tendered his resignation as a member of the Committee. The Committee wishes to express its sincere thanks to the Society both for its financial aid and the fine counsel in the past six years.

Respectfully submitted,
FRANK VAN SCHOICK, M.D., *Chairman*
P. S. BARKER, M.D.
W. B. COOKSEY, M.D.
CARLETON DEAN, M.D.
DOUGLAS DONALD, M.D.
THOMAS FRANCIS, JR., M.D.
S. T. HARRIS, M.D.
H. S. HEERSMA, M.D.
F. D. JOHNSON, M.D.
J. A. JOHNSTON, M.D.
E. C. LONG, M.D.
C. J. POPPEN, M.D.
L. PAUL RALPH, M.D.
MR. EMMET RICHARDS
H. H. RIECKER, M.D.
SAUL ROSENZWEIG, M.D.
D. S. SMITH, M.D.
R. D. TUPPER, M.D.
BERTRAM ZHEUTLIN, M.D.
L. FERNALD FOSTER, M.D., *Secretary*
LEON DEVEL, M.D., *Co-ordinator*

ANNUAL REPORT OF COMMITTEE ON VENEREAL DISEASE CONTROL—1951-52

One meeting of the full Venereal Disease Control Committee was held during the year. Other discussions were held by personal communications throughout the year.

The Committee endorsed the present waiting period of one year after syphilis treatment before marriage.

The Committee also recommended the enforcement by the Michigan Department of Health of the rule requiring private laboratories to report positive evidence of acute communicable disease.

The Committee recommended that a copy of the "Hamilton Kircher Act," which requires prenatal blood tests, be sent to each member of the Michigan State Medical Society and direct attention to the penalty clause.

Other topics of discussion included the spirochaetal immobilization test, various means of publicizing information about venereal disease, the increase of venereal disease in Michigan military installations, case finding programs, and the ban on the terms "gonorrhea" and "syphilis" on radio and television.

Respectfully submitted,
A. C. CURTIS, M.D., *Chairman*
J. A. COWAN, M.D.
RUTH HERRICK, M.D.
R. H. HOLMES, M.D.
H. L. KEIM, M.D.
R. M. KEMPTON, M.D.*
L. W. SHAFFER, M.D.
FRANK STILES, M.D.
R. S. BREAKEY, M.D.

*Deceased.

ANNUAL REPORT OF CANCER CONTROL COMMITTEE—1951-52

The Committee had two meetings during the year, November 8, 1951, and May 8, 1952. Its program was devoted largely to educational activities. It has cooperated wherever possible with other organizations in the cancer field.

The Third Michigan Cancer Conference, sponsored by the Cancer Control Committee and held at the Kellogg Continuing Education Center, East Lansing, on October 12, 1951, in conjunction with the annual meeting of the Michigan Division, American Cancer Society and co-sponsored by the Michigan Department of Health and the Southeastern Michigan Division, American Cancer Society, was attended by about 200 lay and professional delegates. The program was followed by a luncheon and question and answer period. The following program was presented:

Introductory Address.....A. E. Heustis, M.D.
Home Care of Cancer Patients:
Nursing Problems.....Hulda Edman, R.N.
Home Care of Cancer Patients:
Psychiatric Problems.....Harrison Sadler, M.D.
The Problem of Heredity in Cancer Control.....Madge Thurlow Macklin, M.D.
Rural Organizations and the Cancer Problem.....Mrs. Marjorie Karker
Cancer Education in Schools.....F. L. Rector, M.D.

The papers given at the Conference were published in the April, 1952 issue of the JOURNAL MSMS.

The program for the Fourth Michigan Cancer Conference has been completed. It will be held at the Kellogg Continuing Education Center, East Lansing, on Thursday, October 9, 1952, in conjunction with the Annual Training School of the Michigan Division, American Cancer Society and will be co-sponsored by the Michigan Department of Health.

At the request of the MSMS, the Committee has undertaken the organization of a half-day cancer symposium at the 1953 Michigan Clinical Institute. The two Michigan Divisions, American Cancer Society, and the Michigan Department of Health have agreed to co-sponsor this session. Subjects have been selected and speakers invited for this special program.

During the year, the office of the Committee was moved to the Lansing headquarters of the MSMS where it has access to the facilities of the state office for the better conduct of its activities.

The Committee has published "The Role of the Cancer Committee of the County Medical Society in Cancer

Control." Copies have been sent to all officers and Councilors, MSMS; officers and cancer committee members of all local medical societies; local health officers; members of the State Board of Directors and officers, also Commanders of all local units of the Michigan Division, American Cancer Society. This pamphlet discusses in detail the duties and responsibilities of cancer committees in their local areas. The necessity for leadership by the medical profession in all local cancer programs is emphasized.

The Cancer Manual for high schools has undergone final revision and is awaiting funds for its publication and distribution to the public and parochial high schools of Michigan. To place five copies in each high school library for reference purposes, 5,000 copies will be required. It will be too expensive to furnish a copy for each high school student.

A meeting with representatives of the State Department of Public Instruction on February 14, last, was attended by the Chairman and Secretary of this Committee, also by Dr. B. E. Luck, representing the Michigan State Dental Society, and Dr. C. Allen Payne, representing the Michigan Division, American Cancer Society. At this meeting cancer education in high schools was discussed and the desire of this Committee to provide an authoritative source book of information on the subject for both teachers and students was stressed. A copy of the proposed Manual was left with Dr. E. L. Grim and Mrs. McEnaney, representing the Department of Public Instruction, for their examination with the request that, if in their opinion the Manual had value as a source book in its field, the Cancer Control Committee would appreciate a letter of approval from the Superintendent of the Department, Dr. Lee M. Thurston, for inclusion in the printed edition. Such a letter was received from Dr. Thurston promptly (see April, 1952, issue JOURNAL MSMS, page 414).

The Committee has supplied copy for the Cancer Comment page of the JOURNAL MSMS throughout the year.

Representatives of the Committee participated in the meetings of the Committee to Co-operate With Michigan Health Council re Periodic Health Appraisal.

All requests for information or service the Committee could render have been complied with, of which the following are of importance:

At the request of several local Cancer Units a committee member has participated in their lay cancer education programs, especially in the high schools.

By invitation, the Committee was represented at the annual health education conference of the public school teachers of Isabella County in December, 1951.

During the year, two addresses were given at the School of Public Health, University of Michigan.

A Committee member was the speaker at the annual Public Relations dinner meeting of the Macomb County Woman's Auxiliary, MSMS.

Consultations were held with the Health Council and high school authorities of Ottawa County regarding cancer education programs in that county.

Development of cancer programs by local health departments was discussed with representatives of the Michigan Health Officers Association.

The Committee was represented at the Second National Cancer Conference in Cincinnati, Ohio, in March, 1952.

The program of "Every Doctor's Office a Cancer Detection Center" has continued to be stressed in all contacts with physicians and medical groups.

The Hillsdale Plan for Tumor Detection completed its fourth year of operation in Hillsdale County. During the four years, 106 cases of cancer were discovered among the 2,365 individuals examined, a record of 4.58 per cent positive findings. On the basis of total number of examinations made, 4,733, this percentage of positive findings becomes 2.24. These and other details of this project are found on page 412 of the April, 1952 issue of the JOURNAL MSMS.

It is worth noting that, at the 1952, Michigan Clinical Institute, the Hillsdale County Medical Society received from the MSMS a Scroll of Commendation for its cancer detection program which has been widely copied in this country and abroad.

The co-operation of all organizations and individuals that have made the Committee's work effective is gratefully acknowledged.

Respectfully submitted,
HORACE WRAY PORTER, M.D., *Chairman*
F. L. RECTOR, M.D., *Secretary*
F. W. BASKE, M.D.
D. C. BURNS, M.D.
L. C. CARPENTER, M.D.
E. I. CARR, M.D.
R. C. CONNELLY, M.D.
M. A. DARLING, M.D.
H. B. FENECH, M.D.
L. E. HOLLY, M.D.
W. A. HYLAND, M.D.
C. H. KEENE, M.D.
B. E. LUCK, D.D.S.
H. F. MATTSON, M.D.
C. C. MCCORMICK, M.D.
A. B. MCGRAW, M.D.
H. L. MILLER, M.D.
J. D. MONROE, M.D.
H. M. NELSON, M.D.
R. E. OLSEN, M.D.
H. M. POLLARD, M.D.
C. J. POPPEN, M.D.
H. R. PRENTICE, M.D.
J. C. VOLDERAUER, M.D.
J. M. WELLMAN, M.D.
NORMAN F. MILLER, M.D., *Advisor*

ANNUAL REPORT OF MICHIGAN STATE MEDICAL ASSISTANTS ADVISORY COMMITTEE—1951-1952

There have been no formal meetings of the Committee as such during the past year, but on numerous occasions consultation has been sought from various members of the Society individually by members of the Medical Assistants group. Help was given in the revision of the Constitution, and one of our members, Dr. Bromme, was attendant at the annual meeting of the Michigan State Medical Assistants Society, where advice and assistance was rendered in the topics which came up during the meeting. It is the belief of the Committee that the Society is prospering, that it is fulfilling the functions for which it was organized in admirable style, and that excellent co-operation is being accorded the Council of the Michigan State Medical Society, and the profession at large.

Respectfully submitted,
E. A. OSIUS, M.D., *Chairman*
JANE BLUE, M.D.
A. O. BROWN, M.D.
H. H. HEUSER, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE TO BUREAU OF MATERNAL AND CHILD HEALTH—1951-52

There has been no meeting of this Committee for the past twelve months and there have been no communications from the director, G. B. Corneliuson, M.D.

Respectfully submitted,
FRANK VAN SCHOICK, M.D., *Chairman*
C. F. BRUNK, M.D.
A. M. CAMPBELL, M.D.
H. A. FURLONG, M.D.
W. G. HOEBEKE, M.D.
R. B. KENNEDY, M.D.
W. R. KLUNZINGER, M.D.
S. L. LOUPEE, M.D.
R. H. PINO, M.D.
L. P. SONDA, M.D.

ANNUAL REPORT OF THE COMMITTEE ON DEVELOPMENT OF A MODEL CODE FOR M.D. ANNOUNCEMENTS—1951-52

This Committee held two meetings during the year for the purpose of developing a model code covering recommended practices in reference to physician's signs, newspaper, mail and radio announcements and other forms of advertising of any type.

The Committee found that many of the county medical societies have established regulations governing the type and size of physician's signs, and the type of other forms of announcements which may be used. It was the consensus of opinion of the committee that problems of ethics in the last analysis are decided upon according to the Principles of Medical Ethics of the American Medical Association.

The following conclusions were made:

1. The sponsoring of a bowling team or any other athletic team for the purpose of advertising is unethical.
2. Donations to support athletic teams or events is ethical and this applies equally to individuals and to clinics.
3. A neon sign or any other type of advertising of the name of a doctor or of a clinic must conform with the regulations of the local County Medical Society.
4. The problem of advertising of physicians or clinics is a local one and no hard and fast regulations can be set down on a state-wide basis.

Respectfully submitted,
D. Bruce Wiley, M.D., *Chairman*
W. D. Barrett, M.D.
J. E. Livesay, M.D.

ANNUAL REPORT OF COMMITTEE ON ATOMIC AND ALLIED PROCEDURES

An effort was made to have a committee meeting in January, 1952. At this time a letter was forwarded to members of the committee requesting an acceptable date for each individual, and also material for the agenda. Only one written reply was received by the chairman and it was felt that possibly the meeting should be delayed, so the intent was to hold one sometime during the course of the summer, as a number of the members have since been solicited personally for their opinions.

While apparently interest in what this committee might be able to do has lagged, the chairman suggests that it still be retained as a Committee of the Michigan State Medical Society, inasmuch as it still may form a valuable liaison with the physicists, chemists and radiologists composing it, in the event of emergency.

Respectfully submitted,
A. A. Humphrey, M.D., *Chairman*
H. F. Becker, M.D.
O. A. Brines, M.D.
J. E. Cole, M.D.
K. H. Corrigan, Ph.D.
J. J. Grebe, Ph.D.
L. E. Holly, M.D.
Traian Leucutia, M.D.
H. B. Lewis, Ph.D.
M. L. Lichter, M.D.
A. B. McGraw, M.D.
W. L. Mallmann, Ph.D.
W. J. Nungester, M.D.
L. L. Quill, Ph.D.

ANNUAL REPORT OF COMMITTEE ON RURAL MEDICAL SERVICE—1951-52

There have been no formal meetings of the entire Committee to date. Individual members of the Committee have been working and carrying through on the plans and recommendations of the Committee of last year. There has been an increased emphasis on the plan that all county medical societies arrange for coverage and rotating service on days off so that the areas may be covered at all times. The plan of having county medical societies establish information and placement services has been pushed and already this idea has been put into action in several counties. There is a growing need for this type of service each year.

Individual members are working on the above plans in their respective districts at this time. Report to the Committee as a group will be made at a later date.

Respectfully submitted,
E. S. Oldham, M.D., *Chairman*
W. B. Crane, M.D.
J. H. Fyvie, M.D.
O. R. MacKenzie, M.D.
W. H. Mast, M.D.
C. E. Merritt, M.D.
E. S. Parmenter, M.D.
J. R. Rodger, M.D.
F. R. Smith, M.D.
W. F. Strong, M.D.
O. D. Stryker, M.D.
H. B. Zemmer, M.D.

ANNUAL REPORT OF LIAISON COMMITTEE WITH MICHIGAN STATE PHARMACEUTICAL ASSOCIATION—1951-52

One meeting of this Committee was scheduled but was cancelled due to illness of chairman of Pharmaceutical Section. No problems were referred to this Committee.

Respectfully submitted,
J. D. Miller, M.D., *Chairman*
C. G. Clippert, M.D.
C. W. Colwell, M.D.
E. G. Merritt, M.D.
G. H. Rigterink, M.D.

ANNUAL REPORT OF PREVENTIVE MEDICINE COMMITTEE—1951-52

The detailed reports of the several advisory committees offer ample evidence of their accomplishments and continuing good work during the past year.

The Rheumatic Fever Control Committee continues to have as its main objective the maintenance and development of the Rheumatic Fever Centers and has this year sent four Center Representatives to St. Francis Sanatorium in New York for additional education in rheumatic fever control. Next year it is hoped that six chairmen may receive similar fellowships. These will, on their return, spread their acquired information among their respective associates. Periodically the committee is mailing to the profession a desk card of pertinent information on rheumatic fever and plans more educational pamphlets in the future.

The Cancer Control Committee is preparing a cancer manual for use in high schools, a pamphlet for distribution to county medical societies on the role of their cancer committees, and is arranging the program for the Fourth Annual Michigan Cancer Conference in Lansing, October 9 and 10, 1953.

The Venereal Disease Control Committee is currently concerned with the problem of the false positive serological test, the increasing shortage of venereal disease material for teaching purposes and the more complete reporting of venereal disease.

The Industrial Health Committee together with the Michigan Association of Industrial Physicians and Surgeons, sponsored the Third Michigan Industrial Health Day at Flint last May and was represented at the Twelfth Annual Congress on Industrial Health at Pittsburgh last January. "In-Plant" meetings with County Medical Societies are continuing under the sponsorship of this committee and are productive of better understanding by private and industrial physicians of mutual health problems.

The Mental Hygiene Committee has considered a variety of problems, such as "dianetics," the practice of psychotherapy by psychologists and the location of the psychiatric children's hospital. It has prepared and presented

a plan of operation for the State Department of Mental Health. It also prepared an article on the psychiatric aspects of civilian defense which was published in our JOURNAL.

The Geriatrics Committee has devoted most of its time to the study of nursing home regulations and needs. Plans for two three-day institutes throughout the State for nursing home operators and attendants are under way. The publication of a geriatrics number of the MSMS JOURNAL is contemplated.

The Iodized Salt Committee completed a fourth survey of goiter incidence in four Michigan counties and also investigated the availability of iodized salt in Michigan stores.

The Committtee on Infectious Diarrhea plans to publish a brochure on its findings and has arranged to study child deaths in certain areas of the State similar to the studies on maternal mortality.

The Scientific Radio Committee and the Committee on Postgraduate Medical Education continue their very excellent programs which are being modified constantly to meet changing needs.

The committee is grateful for the full and enthusiastic co-operation of the State Health Department and our very capable Health Commissioner, Albert E. Heustis, M.D.

Respectfully submitted,
W. S. REVENO, M.D., *Chairman*
M. R. BURNELL, M.D.
B. E. BRUSH, M.D.
A. C. CURTIS, M.D.
H. H. CUMMINGS, M.D.
A. E. HEUSTIS, M.D.
R. J. MASON, M.D.
H. A. PEARSE, M.D.
H. W. PORTER, M.D.
A. H. PRICE, M.D.
J. M. SHELDON
O. D. STRYKER, M.D.
J. W. TOWEY, M.D.
FRANK VAN SCHOICK, M.D.
R. W. WAGGONER, M.D.

ANNUAL REPORT OF THE MATERNAL HEALTH COMMITTEE—1951-52

Meetings were held August 23, 1951, December 4, 1951, and April 23, 1952. The committee during the year has been co-operating with and assisting the Michigan State Department of Health in setting up rules governing the licensing of Maternity Hospitals.

The problem of the Kahn test during the last thirty days of pregnancy was considered at the April 23, 1952, meeting in Ann Arbor. At that time it was the consensus of opinion that the recommendation of the Venereal Disease Committee favoring this procedure, should stand and that it was written properly by State Department of Health Regulations.

The problem debated throughout the year was the proper method of publishing the maternal mortality statistics so the physicians of the State would derive the most benefit. The yearly report is to be sent to the JAMA and the individual articles to the JMSMS on important causes of death the exact method of contacting the physician was not determined.

Respectfully submitted,
HARRY A. PEARSE, M.D., *Chairman*

G. M. BYINGTON, M.D.
A. M. CAMPBELL, M.D.
G. B. CORNELIUSON, M.D.
A. L. FOLEY, M.D.
FRANCIS JONES, JR., M.D.
H. W. LONGYEAR, M.D.
S. T. LOWE, M.D.
L. C. SPADEMAN, M.D.
P. E. SUTTON, M.D.
D. W. THORUP, M.D.
C. E. TOSHACH, M.D.
KATHRYN O. WEBURG, M.D.
H. R. WILLIAMS, M.D.
P. W. WILLITS, M.D.

ANNUAL REPORT OF COMMITTEE ON INFECTIOUS DIARRHEA—1951-52

There have been no meetings of the Committee on Infectious Diarrhea this year and therefore no report.

Respectfully submitted,
OSCAR D. STRYKER, M.D., *Chairman*
F. M. ADAMS, M.D.
BERNARD BERNBAUM, M.D.
G. D. CUMMINGS, M.D.
J. H. LEWIS, M.D.
K. W. MCLEOD, M.D.
J. G. MOLNER, M.D.

REPORT OF THE COMMITTEE TO STUDY THE LITTLE HOOVER COMMISSION. Report No. 8—1951-52

This committee considered primarily the recommendations of the Little Hoover Commission Report No. 8 concerning the plan for administration of health functions of state government.

The following report was made to The Council as instructed by the House of Delegates:

1. That a strong, over-all central office of health affairs be avoided.
2. (a). To accomplish uniformity of administration that each of the five major divisions of health affairs be controlled by a board having statutory powers. That the administrative or executive head of the department serve at the pleasure of his respective board.
   (b). That an over-all planning commission be established. It would be composed of one member from each of the five governing boards. Its functions would be advisory only and would serve to integrate the health functions of the State and advise the Governor on health functions. The Governor to select the Chairman.
   (c). For instance, the Department of Health would have a governing board with statutory powers which would replace the Health Advisory Committee which now is advisory only. This would then place this department on a parallel with the Crippled Children Commission which already governs with statutory powers. This new governing board would then hire the State Commissioner of Health in the same fashion as the Crippled Children Commission hires its director. In short, we recommend that all five sections of health functions be administered in this fashion.
3. Certain health inspection functions now in the several branches of state government should be transferred to the Department of Health. For instance, the health inspection of taverns now done by the Liquor Control Commission, etc.
4. The Committee concurred in several recommendations of the report as follows: That consideration be given to the problem of raising the quality of personnel in state hospitals and that a more realistic attitude be taken in regard to remuneration. That a codification of all health laws be undertaken. That the School for the Blind and the School for the Deaf remain under the Department of Education and not be transferred to any health agency.
5. The Committee specifically disapproved item No. 8 of the Commission report which would make the present Commissions on T.B., Hospital Survey and Construction, Mental Health, and Crippled and Afflicted Children, only advisory in nature. This conforms to the plan for administration as proposed by this committee in part 2 of this report.
6. This committee disapproves a proposal to amalgamate all the various health examining and licensing boards in one over-all board.

Respectfully submitted,
JACKSON E. LIVESAY, M.D., *Chairman*

O. J. JOHNSON, M.D.
J. G. MOLNER, M.D.
H. MARVIN POLLARD, M.D.
S. B. WINSLOW, M.D.

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

With the spraying and dusting season in full swing, the danger to the home gardener of inseticides containing parathion and tetraethyl pyrophosphate is of growing concern. In the hands of trained and equipped commercial operators, these insecticides were not dangerous, but with their appearance in small packages on seed store shelves the situation changed. These materials, even in mixtures diluted for use or as ready-to-use dusts, contain poison in concentration highly toxic to man.

Doctors are urged to keep in mind the possibility of poisoning from these insecticides if there is any record of contact and if the symptoms warrant. Symptoms of poisoning may include headache, excessive sweating, giddiness, blurred vision, weakness, nausea, cramps, diarrhea and discomfort in the chest. Signs include sweating, constriction of the pupils, epiphora, excessive salivation, cyanosis, convulsions, coma, loss of reflexes and loss of sphincter control. Laboratory findings may be normal except for a lowering of the blood cholinesterase level.

* * *

Short courses to train vision and hearing technicians will be held again this summer. The courses for training locally employed persons to do vision screening will be given at Michigan State Normal College, Central Michigan College of Education and Northern Michigan College of Education and will be taught by the supervisor of the Vision Unit of the Department.

The short course to train locally employed persons to do hearing screening will be held at Michigan State Normal College, taught by Department audiologists.

* * *

The series of regional institutes for food service personnel in small hospitals, county infirmaries, child caring institutions, county homes for the aged and other institutions that proved popular and helpful last summer is being repeated this year. Featured at each institute will be the principles of general menu planning and the problems of special diets. The District Hospital Councils in co-operation with the Michigan Hospital Association, the Michigan Dietetic Association and the Michigan Department of Health are sponsoring the meetings.

* * *

Governor Williams' proclamation designating June as Ragweed Control Month in Michigan has hastened the inquiries from hay fever sufferers for information on pollen-free areas in the state.

Data gathered in the ten years from 1940 to 1950 that the Department carried on state-wide ragweed pollen surveys show that people with ragweed hay fever can find relief in the northern third of Michigan's lower peninsula and most of its upper peninsula.

"Ragweed Pollen in Michigan," a single sheet summary of the findings of the concluding five years' surveys, is available from the Department and gives facts which will help those anxious to avoid high pollen areas. A table and a map for the period 1945-49 show the sixty-two counting stations with their average number of days per year that pollen counts exceeded 100 grains per cubic yard of air in a twenty-four-hour period.

The ten years' experience showed that there is little or no change in the relative distribution of ragweed pollen in Michigan from year to year, but it should be remembered that pollen concentrations vary locally with land and water masses, degree of cultivation of soil, and elevation, and that they are influenced from day to day by wind, rain and sunshine. In Michigan, ragweed begins to pollinate about mid-July but it is not until mid-August that the concentration reaches 100 grains per cubic yard of air per day, the count at which people who are susceptible to ragweed pollen usually show symptoms.

* * *

Traverse City is the latest addition to the list of Michigan cities fluoridating their public water supplies as a preventive of tooth decay among children. This brings to twenty-two the number of cities offering this protection.

* * *

A new pamphlet that physicians may find useful is "If Your Baby is Blind," recently issued by the Department. As the title indicates, it is written for parents of blind or partially sighted babies, giving simple suggestions on care and training. It was prepared for use in the Department's vision conservation program, in answer to a definite need apparently not met by existing publications. The text was first printed in the Department's monthly bulletin and requests have been received from other states for it, one state asking to reprint it.

* * *

The Department is helping to promote the annual institute to be held at the Michigan School for the Blind in August for parents and their preschool children who are so visually handicapped that they cannot attend public schools. If the child is two years of age or older, parents are asked to bring him. The only expense to parents will be transportation and any special food, medicines or equipment that cannot be provided by the school. Details may be obtained from Wallace J. Finch, Superintendent of the School for the Blind, Lansing.

* * *

An accurate diagnosis of a lump in the breast is *only* possible with the aid of a microscope.

* * *

Hormonal therapy should *not be used in undiagnosed* breast tumors.

* * *

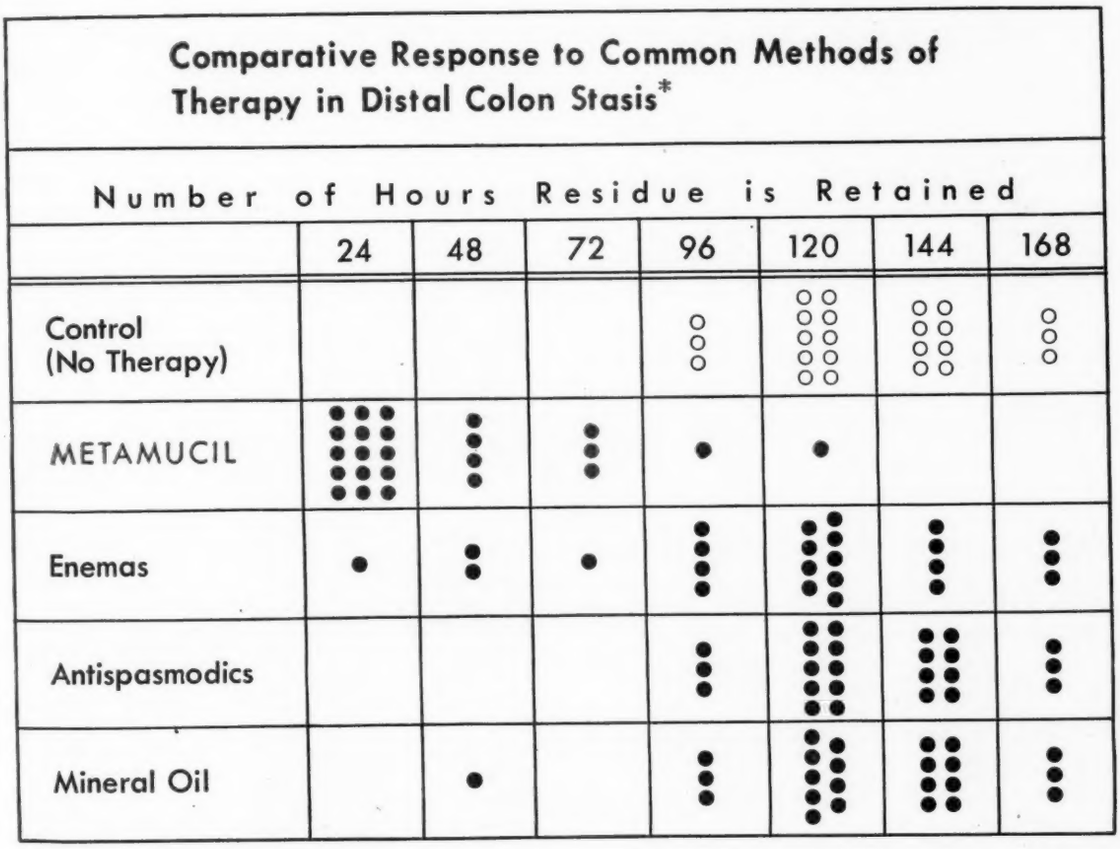
An early cancer of the breast is usually a local cancer and thereby a curable cancer, if properly managed.

METAMUCIL®

Effective in Distal Colon Stasis*

"A roentgenographic evaluation of the common methods of therapy . . . demonstrated that . . . a mucilloid substance (Metamucil) has been most effective in the most prevalent [type of colonic stasis], distal colon stasis. . . . Enemas gave good results in rectal stasis only. Mineral oil had very little effect. Antispasmodics and sedatives had no efficacy. . . . It was found that the use of habit forming cathartics may be avoided in most instances."*

Comparative Response to Common Methods of Therapy in Distal Colon Stasis*



METAMUCIL® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

*Barowsky, H.: A Roentgenographic Evaluation of the Common Measures Employed in the Treatment of Colonic Stasis, Scientific Exhibit, National Gastroenterological Association, Chicago, Sept. 17-22, 1951.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

Correspondence

Wilfrid Haughey, M.D., Editor
610 Post Building
Battle Creek, Michigan

Dear Dr. Haughey:

I am enclosing an interesting clipping out of a recent issue of the *Spectator*. It is very encouraging to note that the British are able to make fun of themselves and of their program of government help. I thought that you might want to read this, and if you thought that it is of general interest, you might wish to put it in the MICHIGAN STATE MEDICAL JOURNAL. Unfortunately, the time may come when our situation here in the United States will be so that we will not consider the verses very humorous.

Yours very sincerely,
HARTMAN A. LICHTWARDT, M.D.
Medical Director

THERE WAS AN OLD WOMAN

There was once an Old Woman who lived in a Shoe;
She had so many children, she didn't know what to do—

They thronged her each morning in urgent resort
With lists far too long for a purse far too short.
There was Tommy demanding a tank and a gun,
And Phil thinking physic and spectacles fun.
Young Bert wanted trucks and new tracks for his trains,
And Ralph helicopters and a—er—o—planes.
As their wants, and the chilidren, grew bigger and bigger,
She near lost her wits, the Shoe quite lost its figure.
"To keep them amused, housed, clad, shod and fed,
Is beyond my poor powers," the Old Woman said.

She went to a Cobbler, and said, "Pray, good soul,
Will you shore up my Shoe—bring it under control?"
He frapped it and lapped it and bound it around,
But your patch will not hold if your garment's unsound;
Those children devised ways round, through and under,
Snapped fingers at her, and the frappings asunder,
And soon, like the Shoe, were all over the place,
Still hungry, still toyless, their clothes a disgrace.

She went to a Planner, and said, "My good man,
Will you fit my affairs to a rational plan?"
He got out his forecasts, his tables, his graphs—
Some looked like sierras and some like giraffs—
But in spite of his graphs, tables, forecasts and charts,
They all went on playing their several parts.

She went to a Statesman, and said, "My good sir,
You have never been known (you have said it) to err:
Pray, what is the matter, and what's to be done?"
He answered, "The cure and condition are one,"
And proceeded to vent a great deal of hot air
About social equality, shares that were fair—
Till at length the Old Woman cried, "Stop, for I think
Your medicine and spectacles both are too pink."

In the end, when she found no advice would avail.
And the Shoe was as wrecked as a castaway whale.
With no loaf in the crock and no cheese on the shelf,
She determined to settle her troubles herself.
"Dear children," said she, "like the Canningite Dutch,
You have offered too little and asked for too much.

But now you must *work* to get out of your fix."
She set the alarm for five minutes to six—

Then she gave them some soup, without any bread,
And whipped them all soundly, and sent them to bed.

JOHN PETRIE.

May 15, 1952

Editor,
Journal, Michigan State Medical Society,
Lansing, Michigan
Dear Sir:

The Thirteenth Precinct Businessmen's Youth Club sponsors a teen-age girls club, "The Thirteeners." Its members come from all precincts of Detroit and meet in the Woodward Station Gym. All teen-age girls are welcome, regardless of race, creed or color. They are *not* delinquents.

Realizing the urgent need for rescue ambulances for use in any emergency throughout the state, especially air crashes, forest fires, bombings, children lost in the woods, et cetera, the Thirteeners have started a drive for funds for a rescue ambulance to be given to the CAP. The 13th Precinct BMYC sponsors three flights.

There are no rescue ambulances in Michigan, and Col. Louis Edwards, Wing Commander, Michigan CAP, urges immediate action in this matter, as a vital emergency defense aid. The ambulance will be used in conjunction with the airplane the BMYC presented to the CAP. It will be equipped with two-way radio. We have Col. Edwards' full co-operation in this venture. He may be contacted at WO. 2-3058, David Whitney Bldg., 1553 Woodward Avenue, Detroit, Michigan.

Contributions for this project should be sent to "The Thirteeners," c/o Thirteenth Precinct BMYC, Box 214, North End Station, Detroit, Michigan.

Sincerely yours,
(Mrs. J.) ELEANOR RIGGS WELLS
Director of Girls' Activities
Thirteenth Precinct BMYC

TEAR SHEDDING DISEASE

The expression "crocodile tears" is a familiar figure of speech to describe hypocritical sorrow. The Roman writer Pliny told the story that this reptile will consume a man's body and limbs, then weep bitterly over his victim's fate. Then he will eat the head. But there is also a disease known as crocodile tears. Dr. Jerzy Chorobski writes about it in the *Archives of Neurology and Psychiatry* (Vol. 65, p. 299). Another name for it is paroxysmal lachrimation. It occurs with patients who have paralysis of the facial nerve. They weep copiously while eating. Chewing without food has no effect. Such persons do not shed tears from any emotional cause. This condition usually lasts for months or years.

Doctor, when you peruse the advertising pages of our journal, remember this: All ads are carefully screened —the items, services and messages presented are committee-accepted. Our standards are of the highest. The advertisers like our journal—that's why they selected it for use in their promotional program. They seek your patronage and your response encourages continued use of our publication. In turn, the advertisers' patronage helps us to produce a journal that is second to none in our state. When you send inquiries, tell them that you read their advertisement in THE JOURNAL of the Michigan State Medical Society.

In Memoriam

LeROY K. ALLEN, M.D., of Roseville, died May 20 at the age of sixty-seven.

For the past thirty years he served the community of Roseville and southern Macomb County as a general practitioner and obstetrician. He was on the Board of Health in Roseville for many years. Doctor Allen was graduated from Wayne University College of Medicine in 1921.

He is survived by his wife, Mrs. Marjorie Allen, and a son, LeRoy Allen.

GEORGE BATES, M.D., of Kingston, died May 13 at the age of ninety.

Doctor Bates, an emeritus member of the Michigan State Medical Society, had practiced medicine in Tuscola County for more than sixty years until his retirement last February. Following his graduation from the University of Michigan Medical School in 1890, he began his practice in Deford. Several years later he established his practice in Kingston where he remained until his death.

Doctor Bates was on the staff of the Hubbard Memorial Hospital in Bad Axe. He is survived by his sister, Mrs. Minnie S. Maynard, of Kingston, and five nieces and nephews.

CHARLES L. BENNETT, M.D., of Kalamazoo, died April 22 at the age of seventy-six.

For the past thirty-three years he served the community of Kalamazoo as a general practitioner. Previous to that, Doctor Bennett had practiced in Gobles, Michigan, after his graduation from the University of Michigan Medical School in 1904.

He was a former president of the Kalamazoo Academy of Medicine. He was extremely active in civic affairs.

Doctor Bennett served as a member of the staff of Borgess and Bronson Hospital. He is survived by his wife, Ethel, and two sons, Keith F. Bennett, M.D., and Gordon J. Bennett of Kalamazoo. He also leaves a sister, Mrs. L. L. Cole, of Paw Paw.

LYNUS T. BRANCHEAU, M.D., of Petersburg, died April 20 at the age of forty-six.

For the past seven years he served the community of Petersburg as a general practitioner. Previous to that Dr. Brancheau had practiced in New Boston, Michigan, after his graduation from Wayne University College of Medicine in 1936.

During World War II he entered the U. S. Navy in 1942 and served for three and one-half years before he was separated from the service in 1945. In that period he served mostly in the South Pacific Theater.

He is survived by his wife, Rita, one daughter, Nanette, four sisters, and three brothers.

(Continued on Page 920)

(Continued from Page 918)

ALEXANDER W. HARPER, M.D., of Flint, died May 3 at the age of seventy-five.

For the past thirty-two years he served the community of Flint as a general practitioner. Previous to that, Doctor Harper had practiced in Manton for seventeen years following his graduation from the Saginaw Valley Medical College, Saginaw, in 1903. He was born in Forest, Ontario.

Doctor Harper was a member of the Genesee County Medical Society and a life member of the Michigan State Medical Society.

He is survived by his wife, Mary; a daughter, Mrs. Joseph Harris, of Detroit; and Homer Harper, M.D., of Flint; two brothers and two sisters.

HUGH HARRISON, M.D., of Detroit, died April 27 at the age of eighty.

Doctor Harrison, who retired from active practice in 1948, had been a member of the staff of Harper Hospital and St. Joseph Mercy Hospital. He was graduated from Michigan College of Medicine and Surgery, Detroit, in 1896.

Doctor Harrison was an honor member of the Wayne County Medical Society and had been active in his county society work for thirty years.

He is survived by his wife, May; and a son, Wesley Harrison, M.D.

ORRIN D. HUDNUTT, M.D., of Plainwell, died April 26 at the age of seventy-one.

For the past nineteen years he served the community of Plainwell as a roentgenologist. Previous to that Doctor Hudnutt had practiced in Otsego and Kalamazoo after his graduation from the University of Michigan Medical School in 1910.

Doctor Hudnutt served his internship at Youngstown, Ohio. He was a member of the Allegan County Medical Society and a former president of the Kalamazoo Clinical Society. Doctor Hudnutt was also a member of the Radiological Society of North America, Inc.

During World War I he served in the Medical Corps.

He is survived by his wife, Ruth, and three children. They are Mrs. Helen Shipman, of Plainwell; Mrs. Jean Berg of Glencoe, Illinois, and Dean Hudnutt, a senior medical student at Western Reserve University School of Medicine.

RAY R. McCRUMB, M.D., of Lansing, died May 5 at the age of sixty-five.

For the past thirty-three years he served the community of Lansing as a general practitioner. Dr. McCrumb was graduated from Wayne University College of Medicine in 1914.

He was a member of the Ingham County Medical Society.

Doctor McCrumb is survived by his wife, Gladys, and

(Continued on Page 922)

RAY R. McCRUMB

(Continued from Page 920)

three brothers. They are Grant McCrumb, of Ypsilanti; Ross McCrumb, of Ann Arbor; and Ford McCrumb, of Eagle.

JOSEPH A. McGARVAH, M.D., of Detroit, died March 20 at the age of seventy.

Doctor McGarvah was graduated from the Detroit College of Medicine in 1905. He interned at Harper Hospital and then established his practice in Fowlerville for twelve years before coming to Detroit. He was a member of the Wayne County Medical Society.

He is survived by five children; a brother, Arthur W. McGarvah, M.D., of Detroit; and four sisters.

CLARK C. PIPER, M.D., of Highland Park, died April 22 at the age of sixty-five.

For the past thirty-two years, he had practiced medicine in Highland Park and Detroit.

Doctor Piper was graduated from Rush Medical College, Chicago, in 1915. He served his internship at Children's Memorial Hospital, Chicago. He was on the staff of the Highland Park General Hospital. Doctor Piper was a member of the Wayne County Medical Society.

He is survived by his wife, Frances, and two children. They are Mrs. Barbara Ann Wiese and Thomas Brian Piper.

CLYDE R. VAN GUNDY, M.D., of Detroit, died May 5 at the age of sixty-five.

Doctor Van Gundy was graduated from the University of Illinois College of Medicine in 1912. He practiced medicine in Peru, Indiana, until he entered the U. S. Army during World War I. After the war, he established his practice in Detroit where he was a member of the surgical staff of Lincoln Hospital. Doctor Van Gundy was a member of the Wayne County Medical Society.

W. EDWARD WOODS, M.D., of Detroit, died April 23 at the age of fifty-eight.

Doctor Woods had practiced medicine in Detroit for more than thirty years. He was one of the original staff members of the Highland Park General Hospital. Doctor Woods was graduated from the University of Toronto Faculty of Medicine in 1920. He was a member of the Wayne County Medical Society.

He is survived by his wife, Joyce; a daughter, Joycelyn; his father, John W. Woods, and a sister, Mrs. W. L. Ham.

In the fiscal year 1952, the Public Health Service will allocate $3,100,000 for cancer work among the states of which Michigan will receive $111,900.

* * *

A tumor of the breast should never be "watched."

* * *

Any lump in the breast is abnormal.

MEDICAL NEWS

MICHIGAN AUTHORS

D. J. Leithauser, M.D.; L. Saraf, M.D., S. Smyka, M.D., and M. Sheridan, M.D., of Detroit, are the authors of an article, "Early Ambulation in Prevention of Postoperative Thromboembolism," published in *The Journal of the American Medical Association,* May 17, 1952.

Laurence Sidney Fallis, M.D., of Detroit, read a paper on "Bilroth I. Gastrectomy" and also was moderator of a panel discussion on "Lower Abdominal Pain" at the Annual Session of the Oklahoma State Medical Association, May 20, 1952.

J. Lewis Dill, M.D., and Donald S. Bolstad, M.D., of Detroit, are the authors of an article, "Further Observations on the Local Use of Cortisone in the Nose in Allergic Rhinitis," published in *Transactions of the American Academy of Ophthalmology and Otolaryngology,* March-April, 1952.

Clifford D. Benson, M.D.; John J. Coury, Jr., M.D., and Donald R. Hagge, M.D., of Detroit, are the authors of an article, "Acute Appendicitis in Infants," published in the *American Medical Association Archives of Surgery,* May, 1952.

John Reid Brown, M.D., and John Wm. Derr, M.D., of Detroit, are the authors of an article, "Arterial Blood Supply of Human Stomach," published in the *American Medical Association Archives of Surgery,* May, 1952.

Henry K. Ransom, M.D., of Ann Arbor, is the author of an article, "Carcinoma of the Colon," published in the *American Medical Association Archives of Surgery,* May, 1952.

O. T. Mallery, Jr., M.D., of Ann Arbor, is the author of an article, "The Industrial Physician, Past, Present and Future," published in *Industrial Medicine and Surgery,* June, 1952.

John K. Ormond, M.D., and P. W. Fairey, M.D., Detroit, are authors of an original article on "Urethral Rupture at Apex of the Prostate" in the May 3, 1952 issue of *The Journal of the American Medical Association.*

Meyer O. Cantor, M.D., Bert E. McCollum, M.D., and Jason Hodges, M.D., Detroit, are authors of an article on "Intestinal Intubation for Barium Produced Bowel Obstruction," published in the *American Journal of Digestive Diseases,* May, 1952.

Meyer O. Cantor, M.D., et al, Detroit, are authors of an article on "Further Simplifying Intestinal Intubation," published in the *American Journal of Surgery,* April, 1952.

John S. DeTar, M.D., of Milan, was among the five men who received alumni awards for distinguished professional and civic service at the annual alumni reunion of Wayne University, Detroit, May 3.

The reunion, commemorating the 84th anniversary of Wayne's founding, was held in the Student Center building on campus.

Dr. DeTar, a 1931 graduate of Wayne's College of Medicine, was named Michigan's Foremost Family Physician in 1948. A general practitioner in Milan, he was recently elected vice president of the American Academy of General Practice. He is a past president of the Washtenaw County Medical Society, an American Medical Association fellow, and a board member of Michigan Medical Service.

Long active in community service, he was organizer of the Milan Boys' Club, Recreation, Community, and Veteran's Councils, and aided in founding the Milan Rotary Club. He obtained and was first president of the Milan Library and also serves as physician for Milan High School athletic teams.

Married, he has four children, John H., Jean, David, and Mary.

* * *

Michigan Health Council has employed Warren F. Tryloff, formerly of Mt. Clemens, as Field Secretary. Mr. Tryloff is a veteran of the Air Force, and a graduate of the School of Business Administration, Michigan State College. During service, he was a German war prisoner for nine months. Mr. Tryloff, who has moved his family to Lansing, will have the main responsibility of expansion of health council activities on the community level.

* * *

The Navy has announced that it will make 176 Naval Hospital Internships available to medical school students who will graduate in 1953. Students interested in a Navy Internship may obtain further information by writing the Surgeon General of the Navy, Bureau of Medicine and Surgery, Navy Department, Washington 25, D.C.

* * *

Louis J. Hirschman, M.D., Traverse City, and Edgar A. Kahn, M.D., Ann Arbor, were guest speakers at the Northern Tri-State Medical Association meeting in South Bend on April 15. Dr. Hirschman's subject was: "Proctologic Diagnosis and Treatment in Office Practice." Dr. Kahn spoke on "Mechanism of the Loss of Consciousness (Head Injuries)."

* * *

The American Congress of Physical Medicine will hold its thirtieth annual scientific and clinical session on August 25 to 29 at the Roosevelt Hotel, New York. For

program, write the Congress at 30 N. Michigan Avenue, Chicago 2, Illinois.

* * *

Great Britain's National health system is costing 50 to 60 per cent more than had been expected and is suffering from serious defects which "appear to be inherent in any system of socialized medicine," according to Ralph A. Reynolds, M.D., who recently returned from his second trip in two years made to England for the purpose of studying its health system. Dr. Reynolds' impressions appear in the May issue of U.S.A.—The Magazine of American Affairs.

Diabetes Week of 1952 will mark the fifth nationwide Diabetes Detection Drive sponsored by the American Diabetes Association.

For further information on this year's drive and on Diabetes Week of November 16 to 22, write the Association at 11 W. 42nd St., New York 36, New York.

The AMA announces that Russell F. Staudacher (formerly associated with the Michigan State Medical Society in its Public Relations Department) will devote full time to the job of Executive Secretary of the Student AMA and also serve as Executive Editor of its journal.

Hiram W. Jones, of Elmhurst, Illinois, has been appointed Executive Secretary of the American Medical Education Foundation (this work formerly being handled by Mr. Staudacher who went to the AMA from Lansing in May, 1951).

Today the Student AMA has approximately 10,000 members in forty-four active chapters with twelve more provisional chapters being admitted next December.

* * *

AMEF: During the first three months of 1952, the American Medical Education Foundation received more individual contributions than during the entire year of 1951.

* * *

R. B. Robins, M.D., Camden, Arkansas, president of the American Academy of General Practice, recently lashed out at "big government" in Washington for regimenting the lives of the American people. "The people"s health has in recent years become a verbal political football for public officials, legislators, bureaucrats, economists, and a wide variety of pseudo-experts with an uncertain knowledge of the subject," stated Dr. Robins who is the elected Democratic National Committeeman for Arkansas. Dr. Robins addressed the National Association of Chain Drug Stores at its Florida convention. He urged the chain druggists to take a more active civic role in problems relating to health.

* * *

Joseph S. Lawrence, M.D., Washington, D. C., who has served as Director of the AMA's Washington Office since 1944, will retire September 1. His successor will be the present Deputy Director, Frank E. Wilson, M.D.

Congratulations, Dr. Lawrence, on a big job well done!

Oregon Decision Leaves Some Questions Unanswered.—We were pleased, of course, with the seven to one decision of the U. S. Supreme Court in throwing out the government's anti-trust charges against the doctors of Oregon who set up their own medical insurance plan. But Bill Holloway, head of our Bureau of Legal Medicine, tells me that the decision still leaves unanswered a number of important basic questions.

For example, is the practice of medicine trade or commerce? Can the operation of a prepaid medical service plan constitute interstate commerce in any case? The decision, he tells me, did not answer these questions; it didn't even hold that the trial court ruled correctly. The Supreme Court merely held that the district court ruling was not "clearly erroneous" on the basis of the evidence presented.

—AMA Secretary Geo. F. Lull, M.D., May 12, 1952.

* * *

Important messages are presented in the advertisements in our journal each month. New products are announced from time to time and information is presented regarding the use of products featured. Other types of ads emphasize services rendered and commodities offered that may be used in your practice, in your office and in your home. Doctor, you can rely on the statements and facts presented. We aim to include only ethical advertisements in our journal. Please tell the advertisers that you saw their advertisements in THE JOURNAL MSMS.

"Your Doctor" Movie to be Distributed Nationwide.—Of special interest to the medical profession is the short subject film—"Your Doctor"—now being released by RKO Pathe to theaters from coast to coast. This seventeen-minute film tells the story of the American Medical Association's contribution to modern medicine in the field of rural health and medical education. It will be available to all theaters through RKO Pathe distribution offices.

* * *

FDA Releases Isoniazid for Prescriptions.—Food and Drug Administration has given drug manufacturers authority to distribute the new anti-tuberculosis drug, isonicotinic acid hydrazide (isoniazid), for use under "close medical supervision." *This means all licensed physicians may prescribe the drug for their patients.* The FDA announcement said approval was granted on the basis of clinical and pharmacological studies reported by drug manufacturers. FDA emphasized that release of the drug implies no approval or endorsement by the agency.

Packages delivered to the druggist by the manufacturer must state: "for use in treatment of streptomycin-resistant tuberculosis, under close supervision of physician," as well as carry the usual caution: "Federal law prohibits dispensing without prescription."

Medical officers of FDA said there has not been sufficient study to determine the place of the new drug in the treatment of tuberculosis. The agency adds:

"Some tuberculosis authorities are of the opinion that the new drug is less effective for patients who are responding to treatment with a combination of streptomycin and para-aminosalicylic acid. *There is growing concern about the possible effects of promiscuous and indiscriminate use* . . . there have been reports of the emergence of resistant strains of tubercle bacilli after varying periods of treatment . . . *the drug should be used in selected cases where it may be a life-prolonging or life-saving measure.*"

AMA's Council on Pharmacy and Chemistry has taken action similar to FDA's regarding various brands of the drug submitted to it for consideration.

* * *

Who Is the Boss?

Who is the boss?
The Man who founded your business or profession?
The President?
The Officers?
The various Department heads?
No, none of these.
I am the reason for this business or profession.
I am the reason for its prosperity.
I am its guiding genius.
I must be served before I bestow my blessings.
I am the end-all and be-all of everything connected with my business or profession.
I am the foundation of its progress.
I am the customer, patient, or client.

Tips for the Doctor's Secretary.—Practical public relations techniques for dealing with the doctor's patients are included in two new illustrated booklets which the American Medical Association soon will make available to physicians. A twenty-page pamphlet—designed as a brief guide for secretaries—will be sent to all AMA members. Especially valuable as a training guide for girls interested in becoming medical secretaries is the sixty-page detailed manual which will be available July 1 to individual physicians through state medical society offices.

* * *

Postgraduate Study.—Samuel H. Rutledge, M.D., Lansing, and **Irwin H. Zielke, M.D.,** of Traverse City, are attending postgraduate courses at the Cook County Graduate School of Medicine.

* * *

Michigan Medical Service.—Enrollment reports as of April 30, 1952, indicated a coverage of 2,478,714, or less than 22,000 from two and a half million. Michigan is the second largest now by only a little over 100,000. Another general solicitation for non-groups will be held July 1 to 25. Anyone under sixty-five may join without the necessity of belonging to a group. The conditions are a little different, but the membership is available.

Indicating the vastness of MMS public trust activities, up to March 31, 1952, it had paid for services to subscribers $71,623,994.57; to veterans $6,119,228.11, a total of $77,743,222.68, and we are now spending for services over a million and a half each month. Paid out

in benefits are 84.45 per cent of receipts, and the administration costs are 9.59 per cent.

We believe our doctors have made an enviable record in the care of the veteran. The first three months of this year the Veterans Administration authorized $353,311.20 for services, and our doctors rendered $252,264.50. They returned the unused 28 per cent of authorizations. For all of 1951 the unused portion was 27.52 per cent.

* * *

Irving I. Edgar, M.D., of Detroit, addressed the annual conference of The Florence Crittenton Homes Association in Chicago, May 27. His subject was, "The Psychological Aspects of Unmarried Motherhood." He also addressed the National Committee on Service to Unmarried Parents in Conjunction with the National Conference of Social Work on May 29.

* * *

Leland E. Holly, M.D., of Ann Arbor, gave a paper on "Dust Diseases of the Lungs" at the May 27 meeting of the Industrial Division of the Greater Grand Rapids Safety Council.

Beaver Island, Michigan, needs a practitioner of medicine. The doctor of medicine who has served Beaver Island is leaving as of September 1.

Beaver Island pays a subsidy of from $5,808 to $6,576 to its doctor. In addition, the physician in past years has had a contract with the U. S. Coast Guard which netted an additional $300 per annum. The Beaver Island physician has the usual privilege of collecting private fees from those able to pay.

For more information, write the Michigan Department of Health, DeWitt Road, Lansing 4, Michigan.

* * *

Oakland County opens second Rheumatic Fever Diagnostic and Consultation Center.—A new Rheumatic Fever Diagnostic and Consultation Center was formally opened May 6, 1952, at the Royal Oak Health Center, Royal Oak, Michigan, to serve Southern Oakland County and adjacent areas of Wayne and Macomb counties. The center offers diagnostic and consultation service for rheumatic fever and rheumatic heart disease on referral

by the family physician. This center is in charge of a panel of consultants headed by J. F. Pearce, M.D., of Royal Oak, and is sponsored by the Rheumatic Fever Committee of the Oakland County Medical Society under the chairmanship of Donald S. Smith, M.D., of Pontiac, in co-operation with the Rheumatic Fever Control Program of the Michigan State Medical Society. Oakland County's first Rheumatic Fever Diagnostic and Consultation Center is located at the Pontiac General Hospital, Pontiac, Michigan.

* * *

Michigan Team Wins AMA State Golfing Trophy.—Wes G. Reid, M.D., of Detroit, with a low gross of 80; Edward F. Kelly, M.D., of Grand Rapids, with 82; Richard H. Sidell, M.D., of Grand Rapids, also with an 82, and G. Donald Albers, M.D., of Grand Rapids, with an 88, bagged the Chicago Medical Society Trophy—a new event in the 1952 American Medical Golfing Association Tournament held at Medinah Country Club in Chicago on June 9 during the AMA Session.

Small replicas of the large Chicago Medical Society Cup were presented to Drs. Reid, Kelly, Sidell and Albers to hold in permanent possession; the trophy itself will rest for one year at the Michigan State Medical Society headquarters in Lansing.

The combined score of the four Michigan medical golfers was the best of any state team among the 215 registrants at this year's AMGA Tournament.

Other Michigan participants in the tournament at Medinah were: Otto O. Beck, M.D., Birmingham; W. C. C. Cole, M.D., Detroit; Russell S. Paalman, M.D., Grand Rapids; F. A. Rice, M.D., Battle Creek; Homer H. Stryker, M.D., Kalamazoo, and Harlan Taylor, M.D., Battle Creek.

* * *

Beaumont Memorial Restoration.—As of June 20, more than $20,000 has been received for the restoration of the American Fur Company's store on Mackinac Island to make it into a permanent memorial to Dr. William Beaumont and to the medical profession of Michigan. The goal is $40,000.

Two letters have gone to all MSMS members, recommending contributions. This project is one that is exclusively the opportunity of the MSMS membership. Only Michigan's doctors of medicine are being invited to contribute to the Beaumont Memorial.

The MSMS Council requests every county medical society to certify the names of its Beaumont Memorial Committee personnel to MSMS. This information is requested by the MSMS Beaumont Memorial Committee and by President Otto O. Beck, M.D.

* * *

Dispensing Barbituric Acid Preparations.—The director of Drugs and Drug Stores, Michigan Board of Pharmacy, invites the attention of all Michigan practitioners of medicine to the dispensing of barbituric acid preparations without proper labeling and marking on the containers dispatched and without the name of the patient. The Dangerous Drug Act specifically provides for such labelling and for the patient's name.

Postgraduate Conference on Prothrombin.—On July 31 and August 1, 1952, a conference on "Prothrombin" will be held, to include the theory of prothrombin determinations, demonstration of the test and facilities for actual performance of the tests. The conference will be held at the College of Medicine, Wayne University, Detroit, Michigan.

The members of the Wayne County Medical Society and of the Michigan State Medical Society are cordially invited to attend this conference It is the purpose of this conference to improve the performance of prothrombin determinations in medical laboratories in Michigan. There will be no charge and no tuition fee. The conference will be held under the auspices of the Michigan Pathological Society and the College of Medicine of Wayne University.

Thursday, July 31, 1952
The College of Medicine—Wayne University

Morning

9:30 Welcome
Dr. H. J. Linn

9:35 Introductory Remarks
Dr. E. R. Jennings

10:00 Review of Modern Concepts of Blood Clotting
Dr. Walter H. Seegers

11:30 Discussion Period
Dr. Walter H. Seegers

Afternoon

1:30 Theoretical Consideration of Methods of Prothrombin Determination
Dr. J. Frederic Johnson

3:00 Demonstration of the Two-Stage Method of Prothrombin Determination
Dr. J. Frederic Johnson
Dr. Edna B. Andrews
Dr. Pietro De Nicola
Dr. Shirley Johnson

Friday, August 1, 1952

Morning

9:30 Influence of Drugs on Prothrombin Time
Dr. E. R. Jennings

10:00 The One-Stage Prothrombin Time: Theoretical Aspects
Dr. V. Schelling

10:45 The One-Stage Prothrombin Time: Practical Application
Dr. Edna B. Andrews

11:30 Demonstration
Dr. Edna B. Andrews
Dr. V. Schelling

Afternoon

1:30 The One-Stage Prothrombin Time: Demonstration: Performance by Students
Dr. Edna B. Andrews
Dr. Pietro De Nicola
Dr. J. Frederic Johnson
Dr. V. Schelling

Parke-Davis President Opens Laboratory at Wayne University.—Preparing the first prescription in the new $30,000 Parke-Davis Pharmacy Laboratory at Wayne University, Detroit, is Harry J. Loynd, president of Parke, Davis & Company. Looking on is Dr. David D. Henry, president of Wayne University, who accepted the new lab in a brief ceremony. Completely equipped for teaching two important branches of the science—operative and dispensing pharmacy—the ultra-modern laboratory contains duplicate facilities to those found in the most modern pharmacies. It was furnished by Parke-Davis, world's largest makers of pharmaceutical products.

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Group Health and Accident Insurance Studies.—MSMS has a Committee on Insurance Studies which is now making a detailed study of group health and accident insurance. The Committee is endeavoring to find the most attractive group health and accident insurance plan for MSMS members based upon a reasonable rate structure. The proposed program already has been discussed with the Executive Committee of the Council; if approved by the whole Council, it will be presented to the MSMS House of Delegates in September.

The eventual decision of the House of Delegates will be forwarded to every MSMS member following the Delegates' Session of September 22-23, 1952.

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Martin J. Urist, M.D., of South Haven, is the author of an article, "Surgical Treatment of Esotropia With Bilateral Elevation In Adduction," published in the *A.M.A. Archives of Ophthalmology*, February, 1952.

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J. S. DeTar, M.D., Milan, was re-elected **Speaker of** the Congress of Delegates of the American Academy of General Practice at its 1952 Atlantic City meeting.

Wilkie M. Drake, M.D., of Breckenridge, **William E. Keane, M.D.**, of Grosse Pointe, **Earl M. McCoy, M.D.**, of Grand Ledge, and **George P. Raynale, M.D.**, of Birmingham, were awarded Golden Anniversary diplomas by Wayne University College of Medicine Alumni Association at the Sixty-Sixth Annual Clinic Day in Detroit, May 14. These four doctors of medicine are the surviving members of the class of 1902.

Principal speaker at the alumni banquet was LeMoyne Snyder, M.D., Lansing, who discussed "Medicine and Homicide Investigation." Frank A. Weiser, M.D., Detroit, was toastmaster.

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John H. Schlemer, M.D., Detroit, recently was elected president of the Wayne County Academy of General Practice. The new vice president is Arthur B. Levant, M.D., Detroit.

Howard C. Rees, M.D., Detroit, is treasurer; William P. Curtiss, M.D., Detroit, is secretary, and Charles W. Sellers, M.D., Detroit, is editor.

Dr. Schlemer, who is a doctor of medicine and a lawyer, was chosen as official parliamentarian at the recent Congress of Delegates of the American Academy of General Practice held in Atlantic City.

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A Horticultural Therapy special course is being inaugurated at Michigan State College, East Lansing, August 4 to 8, 1952. The purpose of this course is to provide practical knowledge for an enjoyable hobby which can be pursued by patients after they leave the hospital, as well as to obtain needed exercise for handicapped limbs and to enhance a patient's social rehabilitation.

Frederick C. Swartz, M.D., Lansing, is among the resource persons aiding this new course.

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

MEDICAL BIOGRAPHIES. The Ailments of Thirty-three Famous Persons. By Philip Marshal Dale, M.D. Norman: University of Oklahoma Press. Price $4.00.

This book is a series of extremely interesting accounts of the medical side of the life and death of thirty-three personages of history: Buddha, Charlemagne, William the Conqueror, Christopher Columbus, Henry VIII, to name a few. The entire list is impressive, the analysis clear, the diagnosis and reasons given, and the last chapter of the book gives the references upon which the deductions are made. Any doctor's library should have this work, especially if he is the least bit interested in history and its relation to medical knowledge, and the influence of medical affairs on history.

Rx FOR MEDICAL WRITING. A useful guide to Principle and Practice of Effective Scientific Writing and Illustration. By Edwin P. Lordan, M.D., and Willard C. Shepard. Philadelphia and London: W. B. Saunders Company, 1952. Price $2.50.

Writing about medical subjects is briefly outlined in the small volume. It tells of the choice of subject, the search for material, the first draft of the paper, the first revision, the second revision, the third revision. The opening of the subject and the end of the paper are important. Illustrations are studied, and good ones suggested. Statistics are important, and if the subject is presented by case reports, that makes very good material, much appreciated by readers. This book is a valuable guide to the young author, and the older one can also profit.

A TEXTBOOK OF PHARMACOLOGY. Principles and Application of Pharmacology to the Practice of Medicine. By William T. Salter, M.D., Professor of Pharmacology, Yale University School of Medicine. Illustrated. Philadelphia: W. B. Saunders Co., 1952. Price $15.00.

In the preface to this text Dr. Salter says, "This is a the choices of one who has spent many hours at the bedside of clinical patients as well as long nights in the laboratory." It is a personal book, and a good one. Although the book is a text and will be used mainly

by students and as a reference, many physicians will enjoy browsing through its pages. The writing style of the author tends to lead you on to the next paragraph. The text is divided into four parts. Part I deals with general principles of pharmacology; Part II with drug action of physiological mechanisms; Part III with application of drugs in clinical medicine; Part IV with toxicology. This book is, in a way, a treatise on pathologic physiology. It is recommended to all physicians.—J.W.H.

ELEMENTARY MEDICAL STATISTICS. The Principles of Quantitative Medicine. By Donald Mainland, M.B., Ch.B., D.Sc., F.R.S.E., F.R.S.C., Professor of Medical Statistics, Division of Medical Statistics, the Department of Preventive Medicine, New York University College of Medicine. Illustrated. Philadelphia: W. B. Saunders Co., 1952. Price $5.00.

The author advises his students in one chapter to read it over rapidly, then over again, learning each definition, and then he will be able to decide. This study enters into the valuation and recording of various facts, findings, procedures; in fact, it concerns every procedure and result in the practice of medicine. The author in one place develops a plan of action with questions: who? why? what? where? when? how? how much? how many? This book is a study in a new field for students who wish to know what to expect, how to find out, why a reaction occurs, and what to do about it. The realm of statistics is not new, but as applied to medicine it is new to most of us. A valuable book, requiring some intensive study at first, but well rewarding the effort.

Classified Advertising

$2.50 per insertion of fifty words or less, with an additional five cents per word in excess of fifty

TECHNICIAN CAPABLE OF MANAGING medical laboratory and x-ray department. Opportunity for advancement. Position available immediately. Woods Medical Center, 19635 Mack Avenue, Grosse Pointe Woods 30, Michigan.

FOR SALE: Twelve years' established practice in small Michigan City; trading center for 20,000. Fully equipped office, low rental or lease. Thoroughly equipped modern hospital. Reply Box 15, 606 Townsend Street, Lansing 15, Michigan.

ACTIVE, Well-established general practitioner in lake suburb of Detroit taking up a residency wishes to have junior associate to take over and purchase practice. Terms should enable net income of at least $1,500 monthly immediately, and new residence may be available. Reply Box 14, 606 Townsend Street, Lansing 15, Michigan.

FOR LEASE: Entire floor (5 rooms and bath) two rooms with wash stands, suitable for doctor's office. Nicely decorated, best location, near hospital. Reply George Hill, 1416 Vine Street, Lansing, Michigan. Phone 2-7238.

FOR SALE: Well-established eye, ear, nose and throat practice. Office fully equipped, near modern hospital. Doctor died suddenly; heirs will make good offer to interested party. Reply Box 151, Houghton, Michigan.

FOR SALE: A $40,00.00 plus, cash practice consisting of general medicine and obstetrics in a very excellent, virtually unopposed rural western Michigan community. Office fully equipped in finest fashion. Hospital facilities convenient driving distance. Obtainable at inventory appraisal for equipment, drugs and supplies. Fine clinic building can be leased. Income could be considerably increased by someone capable and interested in doing surgery. Reply Box 13, 606 Townsend Street, Lansing, Michigan.

WANTED: Physician to take over active medical and obstetrical practice in rural west Michigan Community for a ten-month period beginning August 1, 1952. Excellent facilities. Remuneration and living quarters adequate and desirable. Possibility of later partnership, if mutually desirable. In reply, supply full biographical information and photo. Address Box 10, 606 Townsend Street, Lansing 15, Michigan.

FOR SALE: Cardiotron direct writing electrocardiograph, late model, like new, $450.00. Jones motor driven BMR machine—late model—like new, $150.00. Reply Box 12, 606 Townsend Street, Lansing 15, Michigan.